Caregiver Neglect

VIRTUAL COURSE

TRAINER MANUAL

Academy for Professional Excellence

APSWI
Adult Protective Services
Workforce Innovations

The Academy for Professional Excellence is a project of the San Diego State University School of Social Work

Funding Sources

The training revisions, Version 3, were developed by the Academy for Professional Excellence, with funding from the California Department of Social Services, Adult Programs Division.

Kevin Bigelow and Kat Preston-Wager
Curriculum Developers, Version 3, 2022

Version 1 (2010) and Version 2 (2015) were developed and revised by the Adult Protective Services (APS) Training Project, a project of the Bay Area Academy, San Francisco State University School of Social Work.

Curriculum Developers, Version 1 and 2

Joanne Otto, MSW (2010) and Krista Brown (2015)

Introduction

We are pleased to welcome you to **Caregiver Neglect Trainer Manual**, developed by Adult Protective Services Workforce Innovations (APSWI), a program of the Academy for Professional Excellence under a grant from the California Department of Social Services, Adult Programs Division.

The Academy for Professional Excellence, a project of San Diego State University School of Social Work, was established in 1996 to provide exceptional workforce development and organizational support to the health and human services community by providing training, technical assistance, organizational development, research, and evaluation. Serving over 20,000 people annually, the Academy continues to grow with new programs and a diversity of training focused on serving the health and human services community in Southern California and beyond.

The Academy is a project of San Diego State University School of Social Work (founded in 1963), which offers both a bachelor's and master's degree in Social Work. The School of Social Work at San Diego State University was founded in 1963 and has been continuously accredited by the Council of Social Work Education since 1966.

APSWI is a program of the Academy for Professional Excellence. APSWI is designed to provide competency-based, multidisciplinary training to Adult Protective Services professionals and their partners. APSWI's overarching goal is the professionalization of Adult Protective Services professionals to ensure that abused and vulnerable older adults and adults with disabilities receive high quality, effective interventions and services.

In partnership with state and national organizations, APSWI is developing a national APS Supervisor Core Competency Training Curriculum. This curriculum is developed, reviewed and approved by experts in the elder and dependent adult abuse fields.

APSWI's partners include:
•National Adult Protective Services Association (NAPSA) Education Committee
•California Department of Social Services (CDSS), Adult Programs Division
•County Welfare Directors Association of California (CWDA), Protective Services Operations Committee (PSOC)

Partner Organizations

Dawn Gibbons-McWayne
Program Manager, APSWI
Academy for Professional Excellence
https://theacademy.sdsu.edu/programs/

Kat Preston-Wager
Curriculum Development Specialist., APSWI
Academy for Professional Excellence
https://theacademy.sdsu.edu/programs/

Lori Delagrammatikas
Executive Director
National Adult Protective Services Association (NAPSA)
napsa-now.org

Paul Needham
Chair
NAPSA Education Committee
napsa-now.org

Kim Rutledge
Adult Protective Services Liaison
Adult Protective Services Division
California Dept. of Public Social Services
cdss.ca.gov/Adult-Protective-Service

Francisco Wong and Melinda Meeken
Co-Chairs
Protective Services Operations Committee of the County Welfare Director's Association
cwda.org/about-cwda

THE ACADEMY FOR PROFESSIONAL EXCELLENCE
6505 Alvarado Road, Suite 107, San Diego, CA 92120
Tel: (619)594-3546 – Fax: (619)594-1118 –
http://theacademy.sdsu.edu/programs/

ACKNOWLEDGEMENTS

This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the state and the nation; professional educators; and the Academy for Professional Excellence staff members. APSWI would like to thank the following individuals and agencies:

Agencies
California Department of Social Services, Adult Programs Division
National Adult Protective Services Association

Curriculum Advisory Committee
Ralph Pascual, Human Services Administrator I, Los Angeles County
Jacquelyne Garza, Senior Social Services Supervisor, County of Orange
Jessica Burke, Staff Development Officer, Riverside County
LaTanya Baylis, Training and Development Specialist,
San Bernardino County
Penny Jacobo, APS Supervisor, San Diego County
Whitney Barnes, Social Work Supervisor, Santa Cruz County
Valerie Smith, Social Services Program Manager, County of Santa Clara
Karen Bone, ASOC Client Services Supervisor, Placer County

Committees
National Adult Protective Services Association Education Committee

Curriculum Developers for Revisions, Version 3, 2022
Kevin Bigelow and Kat Preston-Wager

Versions 1 and 2 were developed with help from the following:

Joanne Otto, MSW

Barbara Amaro, MSW

Krista Brown

TABLE OF CONTENTS

GENERAL INFORMATION

WELCOME, INTRODUCTIONS, COURSE OVERVIEW

CAREGIVING AND NEGLECT

NEGLECT DYNAMICS & FINDINGS

RISK FACTORS & RISK INDICATORS

SAFETY & DECISION-MAKING ABILITIES

ASSESSING NEGLECT & BEST PRACTICES

DEVELOPING A SERVICE PLAN

WRAP-UP AND EVALUATION

HOW TO USE THIS MANUAL

This curriculum was developed as an Instructor Led Training (ILT) for in-person training. It may also be trained virtually by modifying timing, activity and engagement prompts as necessary.

- Actions which the trainer takes during the training are written in **bold**.

> **Trainer Notes are written entirely in bold text box and are provided as helpful hints.**

- The participant manual and trainer manual differ in page numbers. It's suggested you note the participant manual page number for activities and handouts to reference during training for ease.

Use of language: Throughout the manual, APS professional is used most often to describe APS line staff. The term client is used most often to describe the individual at the center of the APS investigation. However, if concept or material was directly quoted from copyrighted material, another term may be used.

"He" and "she" have been replaced with the gender-neutral "they" throughout this manual, unless quoted from copyrighted material. This should not be thought of as plural persons, but rather a gender-neutral term describing all humans.

Customizing the Power Point:

Hide a Slide Instructions:

1. On the Slides tab in normal view, select the slide you want to hide.
2. On the Slide Show menu, click Hide Slide.

The slide number will have a line through it to show you have hidden it.
NOTE: The slide remains in your file even though it is hidden when you run the presentation.

The course outline is the class schedule used for development of this curriculum. It can be used to help determine how much time is needed to present each section. However, times will vary based on the experience and engagement of the audience.

Participant Manual:
The Participant Manual should be provided to each participant either hard copy or sent ahead of time as a fillable PDF if using Adobe Acrobat.

TRAINER GUIDELINES

It is recommended that someone with experience investigating and developing services plans in cases where neglect by others is alleged train this course.

The optimal size for this virtual training is 20-25 participants.

Teaching Strategies	The following instructional strategies are used: • Lecture segments • Interactive exercises (e.g., role play, video demonstration and breakout groups) • Question/answer periods • PowerPoint Slides
Materials and Equipment	**The following materials are provided and/or recommended:** 1. Trainer Manual 2. Participant Manual (fillable PDF) 3. PowerPoint Slides 4. Video clip

Executive Summary

Course Title: Caregiver Neglect

Course Description:
In this engaging introductory training, participants will: explore various types of caregiving challenges and situations, examine possible risk factors, indicators and causes of neglect, and discuss the importance of the criminal justice system in situations that result in serious bodily injury. Participants will also learn interviewing best practices in caregiver neglect allegations, discuss considerations in developing a service plan, and explore possible prevention strategies.

The following instructional strategies are used: lecture segments, interactives activities/exercises (e.g. small group discussion, experiential exercise as a role play); question/answer periods; PowerPoint slides; participant manual (encourages self-questioning and interaction with the content information); and video demonstrations.

Target Audience:
This course is designed for new APS professionals as well as Aging & Adult Service Partners (e.g. IHSS, Public Guardian, and Mental Health). This training is also appropriate for senior staff that require knowledge and/or skills review.

Learning Objectives:
Upon completion of the training, participants will be able to:

- Identify physical and behavioral indicators of neglect.
- Identify factors that contribute to the client's risk of neglect.
- Assess allegations of caregiver neglect using five domains of assessment.
- Explain how dynamics of caregiver neglect impact service planning and describe barriers to service planning.
- Identify useful interviewing techniques when interviewing alleged perpetrators.
- Define components of service planning.

The APSWI website offers a number of training tools including videos and other resources that may be useful to APS staff with various experience levels. These materials can be found at:
https://theacademy.sdsu.edu/programs/apswi/

Course Outline

CONTENT	MATERIALS	TIME
WELCOME, INTRODUCTIONS, COURSE OVERVIEW		**TOTAL: 20 minutes**
Housekeeping Technology Participant Intro		
Activity #1: Is there a Difference? (*Large Group*) Learning Objectives and Course Overview		10 minutes
NEGLECT OVERVIEW		**TOTAL: 40 minutes**
Definitions: • Neglect (Types) • Caregiver • Activity #2: Leonard Case Example *(Large Group)*		
Formal and Informal Caregivers		
State Statutory Definitions • CA Statutes (replace if not in CA) • Criminal Neglect • Activity #3: Case of the 59-pound Victim-PART 1 (*Large Group*) • Serious Bodily Injury	• Handout #1 • Case Scenario	
Working with Law Enforcement • Language • Possible Benefits		
NEGLECT DYNAMICS & CONSIDERATIONS FOR APS		**TOTAL: 40-45 Minutes**
Theories • Situational • Exchange		

• Social Learning • Political/Economic • Psychopathology		
Additional Dynamics • Activity #4- What Dynamics are Present? (*Individual, Large Group*)	• Handout #2	10 min
RISK FACTORS AND RISK INDICATORS		**TOTAL: 50-60 minutes**
Client Risk factors Risk Indicators • Physical • Behavioral • Activity #5- Responses to Behavioral Indicators (*Breakout Groups*)	• Handout #3 • Handout #4	25 minutes
Risk Factors (Perpetrators) Risk Indicators • Activity #6- Barbara Case Example (*Breakout Groups*)	• Handout #5	15 minutes
ASSESSING NEGLECT IN FIVE DOMAINS		**TOTAL: 50 minutes**
• Safety and Risk • Living Environment • Physical/Medical Impairments • Financial and Social Situation		
• Decision-Making Ability and Capacity • Client's Right to Self Determination		
• Activity #7-= Enid's Case Example (*Breakout Groups*)	• Handout #6B	25-30 minutes
INTERVIEWING BEST PRACTICES		**TOTAL: 60-65 minutes**
• Interviewing Best Practices • Activity #8- Video Demonstration (*Individual and Large Group)* • When Alleged Perpetrator Begins to Talk • Activity #9- Follow Up Questions (*Individual and Large Group)*	• Handout #7 • Video Clip • Handout #8B	10-15 min 10 minutes
Other considerations • Activity #10- Interviewing Jacob (*Pairs*)	• Handout #9 • Handout #10	25 minutes

SERVICE PLANNING		**50 minutes**
Developing a Service Plan: • Five Domains • Services for Caregivers • Activity #11- The Service Plan (*Breakout Groups*)	• Handout #11	30-40 minutes
LESSONS LEARNED AND EVALUATIONS		**15 minutes**
• Key takeaways • Evaluations		
TOTAL (EXCLUDING BREAKS)		**5.5 hours**

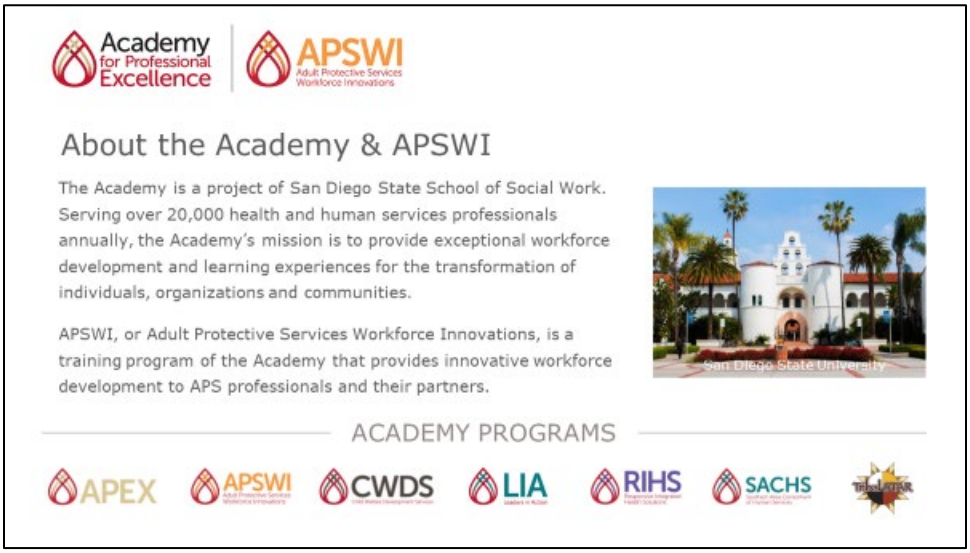
WELCOME AND OVERVIEW
Time Allotted: 20 minutes

Slide #1: Welcome

Welcome participants to this Caregiver Neglect training.

Allow for participants to settle in.

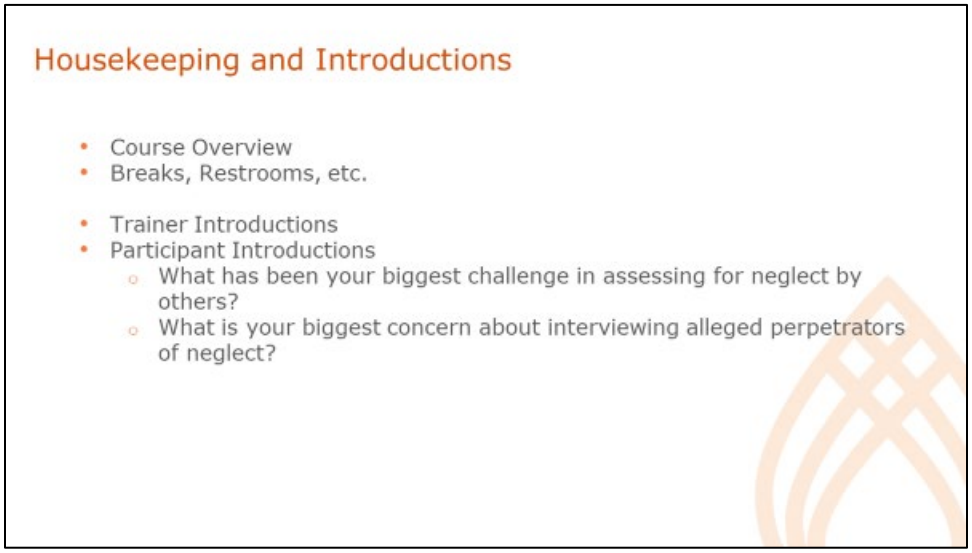
Slide #2: About the Academy and APSWI (1 minute)



Explain that the Academy for Professional Excellence is a project of San Diego State School of Social Work. Its mission is to provide exceptional workforce development and learning experiences for the transformation of individuals, organizations and communities.

Explain that Adult Protective Services Workforce Innovations (APSWI) provides innovative workforce development to APS professionals and their partners. APSWI is a program of the Academy for Professional Excellence along with others listed on the slide.

Slide #3: Housekeeping and Introductions

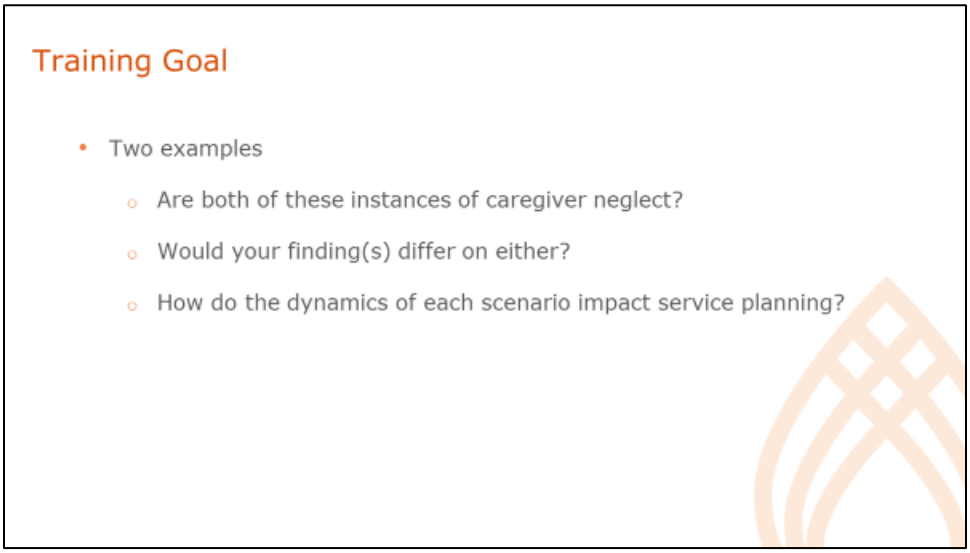


Review the following:

- **Schedule for the day** – Briefly **review** the agenda – breaks, lunch, etc. which is located in the participant materials (there will be two 15-minute breaks and an hour for lunch today). Take a moment to **orient** training participants to their Participant Manual – PowerPoint, handouts, activities, resources.
- **Housekeeping** – **Remind** everyone to silence electronic devices and take the time to be present in these trainings. **Announce** restroom location, emergency exit information, and to please return from breaks on time.

- **Introductions**: **Introduce** yourself – background, position within APS, etc.
  Participant's introductions – **ask** participants to:
  - Self-introduction including name, job title, agency, and how long in position.
  - Share their biggest challenge in assessing reports of neglect by others.
  - Share their biggest concern about interviewing alleged perpetrators of neglect.

Slide #4: Training Goal



Activity #1- Is there a Difference? (10 min)
Large Group discussion

Explain that you will be sharing two brief examples of caregiver neglect allegations.

Ask for a volunteer to read out loud Scenario One from their participant manual:

Case Scenario 1:

- APS responds to a report of caregiver neglect and interviews the partner and caregiver of Miles Framer, who is living with Alzheimer's. They explain that they have been tying Miles to the bed, around his waist at night because he gets up and wanders away from the house. APS explains that this is dangerous due to many safety concerns and can be a form of caregiver neglect. They burst into tears and say, "I don't know what to do. I can't afford any help and I'm afraid that he will wander off and get hurt." APS discusses the possibilities for installing door chimes, IHSS for caregiving services, and medical alert button and/or GPS tracking device to put on Miles so that police can identify where he lives if he wanders off. They agree to try all of these suggestions and are grateful for the support and options.

Ask for another volunteer to read out loud Scenario Two from their participant manual:

Case Scenario 2:

- APS responds to a report of caregiver neglect and interviews the adult child

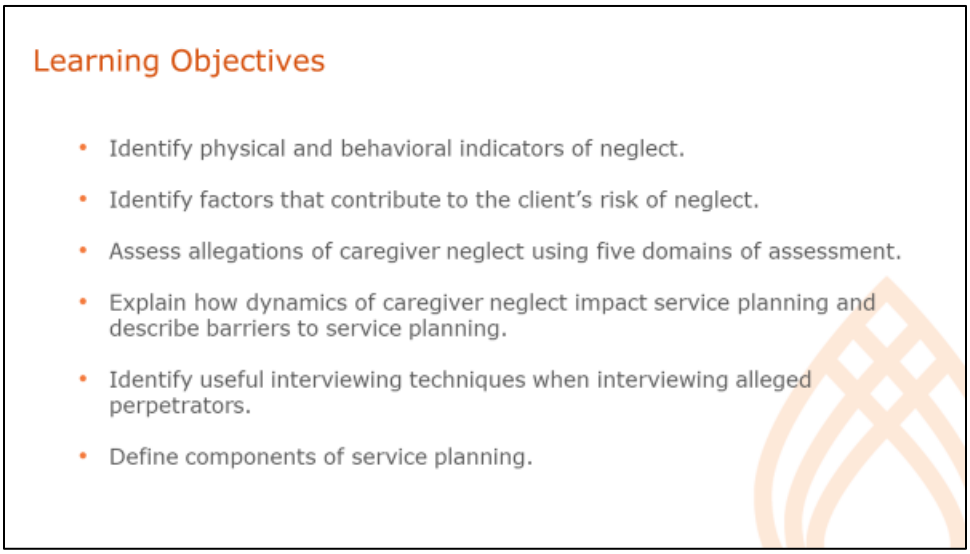
and caregiver of Bodie Neex, who is living with Alzheimer's. The caregiver admits to tying their father to the bed, around his waist at night, because "when I was a kid, he used to lock me up when I was acting out and now it's his turn. He deserves it!" APS explains that this is dangerous for many safety concerns and can be a form of caregiver neglect. They reply, "Well, then I wouldn't have to take care of him anymore."

Briefly invite comments on the below prompts:

1. Are both of these instances of caregiver neglect?
2. Would your finding(s) differ on either?
3. How do the dynamics of each scenario impact service planning?

Explain that these two scenarios showcase some of the dynamics when responding to caregiver neglect. Today's training will work through common challenges, experiences and questions when it comes to working with allegations of caregiver neglect.

Slide #5: Learning Objectives



Briefly paraphrases the learning objectives.

- Identify physical and behavioral indicators of neglect.
- Identify factors that contribute to the client's risk of neglect.
- Assess allegations of caregiver neglect using five domains of assessment.
- Explain how dynamics of caregiver neglect impact service planning and describe barriers to service planning.
- Identify useful interviewing techniques when interviewing alleged perpetrators.
- Define components of service planning.

Explain: We will start out this training by exploring the definitions of neglect, then discuss the importance of involving the criminal justice system in situations of neglect that result in serious bodily injury. We will cover basic information about both the clients and the alleged perpetrators, the possible causes of caregiver neglect, and assessing neglect while accounting for various issues, including capacity and caregiver/client dynamics.
Later in the training, we will examine caregiver stress, some of the excuses or justifications caregivers use, interviewing best practices, considerations of developing a service plan, and possible prevention strategies.

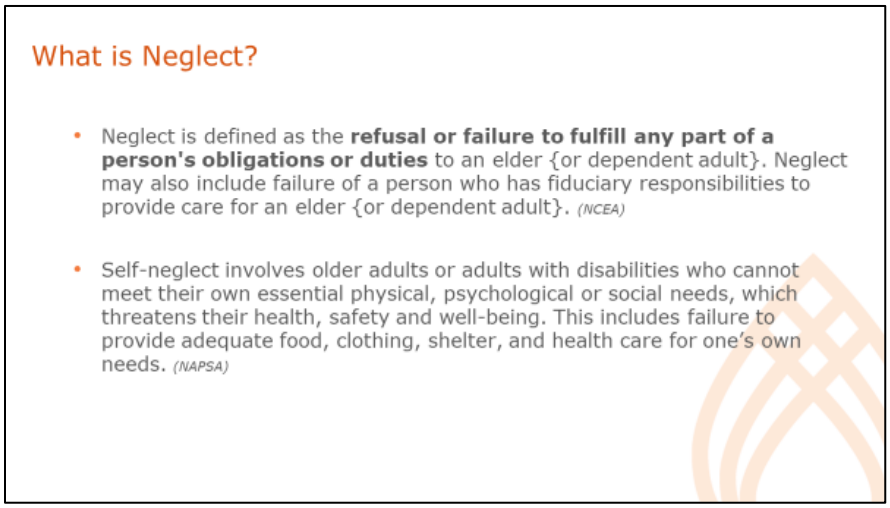
During this training you will be asked to engage in activities of experiential learning that will involve taking chances in order to build your confidence as an APS professional. Being an active participant in training activities can bring up uncomfortable feelings for a variety of reasons. Where there might be discomfort, we invite you (if it's safe to do so) to develop awareness of these feelings and allow them to simply be. The goal of this training is to

foster a learning environment that supports your ability to practice new skills throughout the training.

NEGLECT OVERVIEW
Time Allotted: 40 minutes

Slide #06: What is Neglect?

Trainer Note: This slide is animated to first define Neglect as the umbrella term. After clicking, define Self-Neglect. Explanations are below.



Ask training participants if any of the words in the definition for neglect jump out at them and why.

Explain: This definition for neglect is from the National Center on Elder Abuse (NCEA), but in your practice, you will need to be familiar with the exact definitions spelled out in your own state elder abuse/APS statutes.

- Knowing these specific terms will enable you to assess whether a client meets the same criteria for the provision of elder/dependent adult abuse/APS services.
- While all state elder/dependent adult abuse/APS statutes include neglect, the definitions may differ. The important concept to remember that neglect involves the failure to provide essential services. Neglect is an act of omission, not commission.
- Neglect is often the larger term to describe failure to meet a person's essential needs or services. In some states, like CA, there is also a self-neglect statute. In the CA Welfare and Institution Code (W&IC), self-neglect comes under the neglect umbrella.

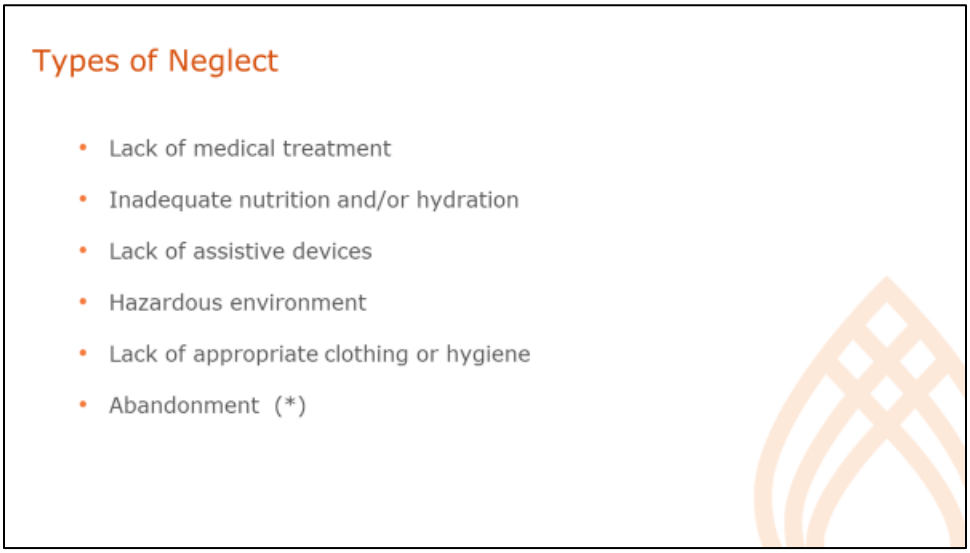
Click to define self-neglect according to National Adult Protective Services Association (NAPSA).

Give participants 2-4 min to individually read over neglect and self-neglect and write down in their participant manuals why it is important to differentiate between the two.
After participants have had time to write down individually, **ask** for volunteers to share.

Emphasize that this training focuses specifically on caregiver neglect, but

APS should always keep self-neglect in mind as the differences between the two will have an impact on their findings and service plans.

Slide #07: Types of Neglect



A person who is being neglected by their caregiver may experience several types of neglect at the same time that may vary in intensity. Neglect may worsen existing medical conditions leading to the client's compromised ability to make informed choices or to voice their concern about the lack of care.

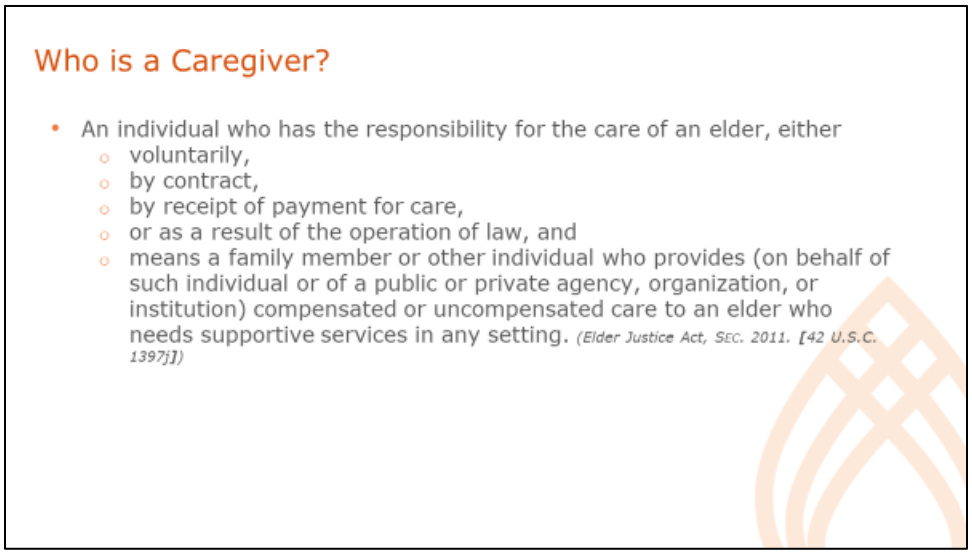
- **Lack of medical treatment** – Medical neglect means that the client has not received appropriate and/or timely medical attention for their physical well-being. Medical neglect may also include the fact that the client is not getting needed prescribed medications or treatment, that the medications are outdated, or that the client is being over or under medicated in order to reduce the amount of time or effort to take care of them. Medical neglect can also happen when the caregiver doesn't follow physician or providers orders including refusing Home Healthcare services.
- **Inadequate nutrition and/or hydration** means that the client is not receiving enough food or liquids, or that what is provided is not appropriate for their condition.
- The **lack of assistive devices** may have devastating effects on the client. Without dentures, for example, the client's nutrition is compromised. A lack of assistive devices can result in the client being more dependent on the caregiver, and thus more subject to the caregiver's control.
- A **hazardous environment** puts the client at risk of fire, disease, heat exhaustion, hypothermia, falls, and can restrict access to necessary spaces, such as kitchens and bathrooms. Lack of sanitation may mean unsafe drinking water. Vermin also thrive in dirty dwellings,

spreading disease.

- **A lack of appropriate clothing or hygiene** means that the client may suffer from hypothermia or hyperthermia (overheating), and that they may be more susceptible to infections due to lack of cleanliness.
- **Abandonment** is the desertion of an older or vulnerable adult by an individual who has assumed responsibility for providing care for the person, or by an individual who has physical custody of the person. Not all state elder/dependent abuse/APS statutes include abandonment as a specific form of elder/dependent adult abuse. However, when a person who has assumed responsibility for providing care to an older or dependent adult deserts the person for whom they have assumed responsibility for, that constitutes neglect, which is included in every state elder/dependent abuse/APS statute.

Slide #08: Who is a Caregiver?

Trainer Note: This slide is animated to ask a prompt prior displaying the slide.



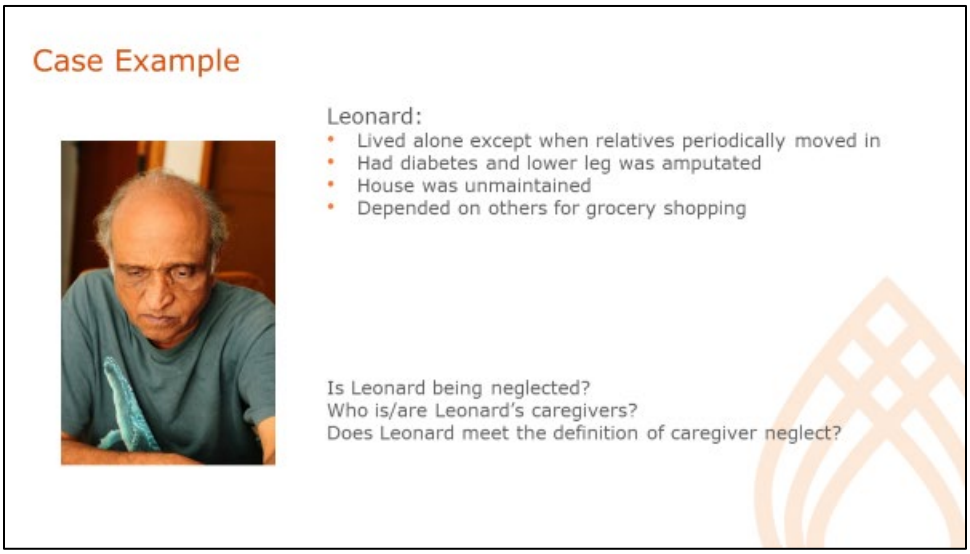
Before advancing the slide, **ask**: "What types of caregivers have you encountered? Any caregiving situations you felt were unusual?"

In thinking about caregiver neglect, consider the following:

- Caregiving involves many activities.
- Sometimes these duties are not clearly defined.
- The amount and intensity of these responsibilities often increase over time due to the care needs changing.
- Think about your own values as you investigate caregiver neglect.
- Some caregivers may lack adequate resources or information to carry out this role.
- How can we approach these cases from a culturally responsive approach?
    - Being culturally responsive can mean you "have the ability to learn from and relate respectfully with people of your own culture(s) as well as those from other culture(s)." (National Center for Culturally Responsive Educational Systems, NCCREST, 2008) Be mindful how your own values might impact some of your judgements when investigating these types of allegations.

Share the definition on the slide from the Elder Justice Act and **explain** that although each state's statutes will define caregiving in depth, concepts from this definition like "responsibility for the care" "contract", "payment" "compensated or uncompensated" "who needs supportive services" will be woven throughout this training and are important concepts to keep in mind when investigating these allegations.

Slide #09: Case Example



Activity #2- Leonard Case Example (10 min)

Large Group

- **Refer** participants to the Leonard Case Example in their participant manuals.
- **Ask** for a volunteer to read the case example out loud.
- As a large group **answer** the questions following the scenario.

Scenario

Leonard was widowed and lived alone. He had one daughter, Marcella, who lived 50 miles away and seldom visited him. However, he had a number of relatives – nieces, nephews, cousins, and in-laws who periodically moved in with him when it suited their needs. However, once they found jobs, worked through their relationship breakups and/or started their recovery process or relapsed, they moved out. Due to diabetes, Leonard's left leg had been amputated at the knee, so he used a wheelchair to get around the house. There was no shower in the house, only a bathtub, which he could not use by himself. He washed himself in the bathroom sink and was generally fairly clean. But the house itself was filthy. There were trash and dirty clothes scattered everywhere. The kitchen sink was always full of dirty dishes, and all the surfaces were coated with dust and grime. The yard was littered with machine parts and broken appliances.

Leonard was unable to drive so he depended on his housemates to buy groceries, run errands, take him to the clinic, and pick up his prescriptions. The few friends he once had stopped visiting him, due to the general chaos at his home. He had a phone, but it was always tied up by others in the

house. He said that he was not lonely, yet there was no one who really listened to him.

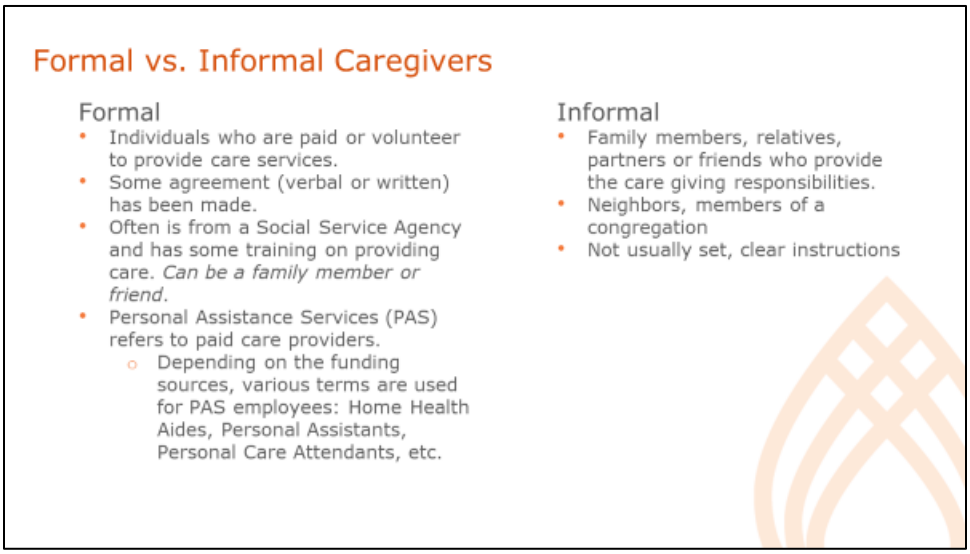
Someone in the household usually brought groceries, as meals were shared by everyone who lived there. But depending on who did the shopping, Leonard did not always get the food he needed to maintain a diabetic diet. There was not one reliable person on whom he could depend on. As a result, his weight and glucose scores increased, and he became more inactive and lethargic.

Ask training participants the following questions (answers are in **bold**):

- Is Leonard being neglected?
  Yes
- Who is/are Leonard's caregivers?
  No one has been identified as his caregiver.
- Does Leonard meet the definition of caregiver neglect?
  No, because there is no identified caregiver.

Sometimes it is not clear who the designated caregiver is. In Leonard's case, there appears to be no one who has assumed or been given the responsibility to assist Leonard. However, Leonard could still qualify for protective services since Leonard is not receiving "the essentials necessary to maintain Leonard's health and safety." Leonard would meet most state definitions for self-neglect.

Slide #10: Formal vs. Informal Caregivers



When investigating allegations of caregiver neglect, it can be challenging to agree on if the person carrying out specific duties identifies as a caregiver. It may be easier to recognize formal caregiving, but informal caregiving is still being a caregiver and therefore still could be at risk for neglecting a client.

To differentiate between the two using the NCEA's definition of neglect earlier, someone may identify themselves as "formal" if they have specific duties assigned or have fiduciary responsibilities. However, others that are not compensated and/or are family members, may inform you they are the client's formal caregiver as they may have quit their job to take care of the client or have some sort of agreement with the client.

The perception of what makes a caregiver "formal" varies. In general, someone could be perceived or is a formal caregiver when:

- There are verbal or written agreements (a schedule to follow, information provided on bills to pay/access granted to bank accounts)
- Paid by other family members or client themselves to care for the client
- Employed by an agency
- Volunteer basis (church, interns)

For the most part, informal caregivers do not have a set of clear, written or verbal expectations about what duties they are expected to perform, nor does anyone routinely oversee or supervise their work.

- Helping a neighbor (taking to doctors, doing laundry or cleaning, grocery shopping) can be perceived as formal caregiving from the

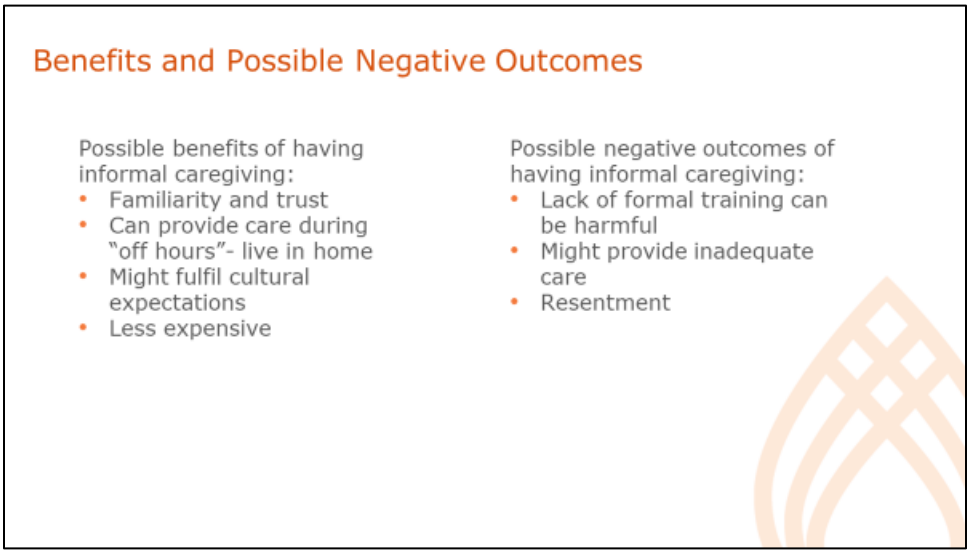
community, though the person doesn't think of themselves as a formal caregiver.

In terms of family members as caregivers**,** according to a report by the AARP: "As of 2015, about 17% of adults ages 18-plus, or 39.8 million adults, in the United States were caring for an adult loved one." In 2020, AARP Caregiver research on caregiver profiles found that "The typical family caregiver is a 49 year-old woman (although AARP policy research shows that 40% are men). The loved one being cared for is typically a woman who is 69 years of age."

https://www.aarp.org/research/topics/care/info-2018/state-caregiver-profiles.html

Slide #11- Benefits and Possible Negative Outcomes

Trainer Note: This slide is animated to allow participants to first respond to the (2) questions for the activity.



In-person delivery: **Have** participants turn to a partner and answer the following questions. **Give** them 3-5 minutes and then **process** as a large group.

Virtual delivery: **Ask** participants to individually answer the questions for 3-5 minutes and then **process** as a large group.

What are some of the benefits of having informal caregivers?

Possible answers:

A. *Caregiver knows the patient, is a trusted person*
B. *Caregiver gives needed assistance without watching the clock*
C. *Caregiver may provide emotional support as well as physical care*
D. *Continuity of caregiver from one day to the next*
E. Caregiver may live in the home, therefore be available more often and during overnight.

What are some of the possible negative outcomes of having informal caregivers?

Possible answers:

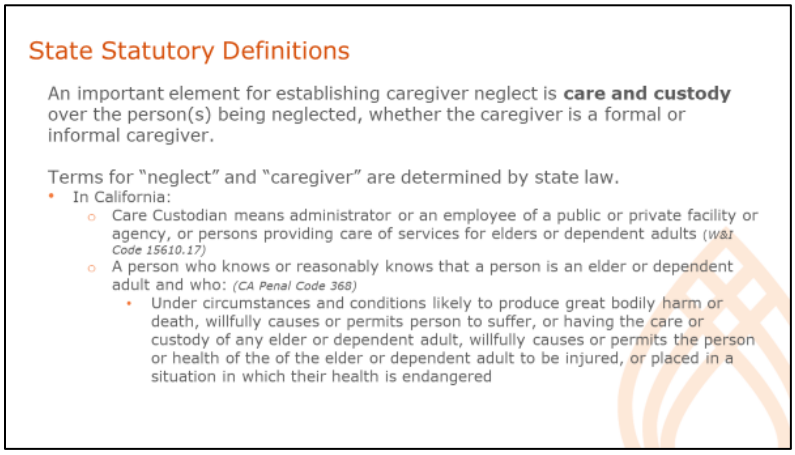
A. *Lack of identified responsible person means that sometimes that inadequate or no care is provided*

B. Lack of clear expectations about roles and responsibilities means that essentials tasks may not be provided consistently, or may be harmful to the patient
C. Lack of accountability and no penalties for failure to perform services may result in the patient being neglected and/or harmed
D. Lack of "formal" training and/or lack of experience to deal with complex health/cognitive/behavioral issues
E. The person available to be the caregiver may not be the best equipped for the job.
F. There is a risk that the informal caregiver could be a predator or opportunist looking for someone to exploit.

Slide #12: State Statutory Definitions

Trainer Note: If training outside of CA, replace Handout #01 with your state's statutes.

If training in CA, familiarize yourself with this handout and be prepared to review items related to this training on neglect.



Review the slide:

- When APS investigates this type of allegation, the importance is who had care and custody of the client at a specific time, thus making them a caregiver, not so much if it was formal or informal.
    - We will address this more in depth when we discuss interviewing and investigating this type of allegation.
- California State Statutes:
    - Care Custodian means administrator or an employee of a public or private facility or agency, or persons providing care of services for elders or dependent adults (*W&I Code 15610.17)*
    - A person who knows or reasonably knows that a person is an elder or dependent adult and who: *(CA Penal Code 368)*
    - Under circumstances and conditions likely to produce great bodily harm or death, willfully causes or permits person to suffer, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the of the elder or dependent adult to be injured, or placed in a situation in which their health is endangered

Review Handout #1- CA State Statutes briefly with participants **highlighting** terms and areas related to neglect.

- **Ask** if any of the concepts or terms jump out at them and why.

Handout: #01: State Statutory Definition for California

California Penal Code, Section 368

(https://leginfo.legislature.ca.gov/faces/printCodeSectionWindow.xhtml?lawCode=PEN&sectionNum=368.&op_statues=2018&op_chapter=70&op_section=3) **PART 1. OF CRIMES AND PUNISHMENTS [25 - 680.4]** *(Part 1 enacted 1872.)* **TITLE 9. OF CRIMES AGAINST THE PERSON INVOLVING SEXUAL ASSAULT, AND CRIMES AGAINST PUBLIC DECENCY AND GOOD MORALS [261 - 368.7]** *(Heading of Title 9 amended by Stats. 1982, Ch. 1111, Sec. 2.)* **CHAPTER 13. Crimes Against Elders, Dependent Adults, and Persons with Disabilities [368 - 368.7]** *(Chapter 13 heading added by Stats. 2010, Ch. 617, Sec. 2.)*

(a) The Legislature finds and declares that elders, adults whose physical or mental disabilities or other limitations restrict their ability to carry out normal activities or to protect their rights, and adults admitted as inpatients to a 24-hour health facility deserve special consideration and protection.
(b) (1) A person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars ($6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.

(2) If, in the commission of an offense described in paragraph (1), the victim suffers great bodily injury, as defined in Section 12022.7, the defendant shall receive an additional term in the state prison as follows:

(A) Three years if the victim is under 70 years of age.

(B) Five years if the victim is 70 years of age or older.

(3) If, in the commission of an offense described in paragraph (1), the defendant proximately causes the death of the victim, the defendant shall receive an additional term in the state prison as follows:

(A) Five years if the victim is under 70 years of age.

(B) Seven years if the victim is 70 years of age or older.

(c) A person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars ($2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

(d) A person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars ($2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars ($10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars ($950).

(2) By a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars ($950).

(e) A caretaker of an elder or a dependent adult who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of that elder or dependent adult, is punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars ($2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars ($10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars ($950).

(2) By a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars ($950).

(f) A person who commits the false imprisonment of an elder or a dependent adult by the use of violence, menace, fraud, or deceit is punishable by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years.

(g) As used in this section, "elder" means a person who is 65 years of age or older.

(h) As used in this section, "dependent adult" means a person, regardless of whether the person lives independently, who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. "Dependent adult" includes a person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(i) As used in this section, "caretaker" means a person who has the care, custody, or control of, or who stands in a position of trust with, an elder or a dependent adult.

(j) Nothing in this section shall preclude prosecution under both this section and Section 187 or 12022.7 or any other provision of law. However, a person shall not receive an additional term of imprisonment under both paragraphs (2) and (3) of subdivision (b) for a single offense, nor shall a person receive an additional term of imprisonment under both Section 12022.7 and paragraph (2) or (3) of subdivision (b) for a single offense.

(k) In any case in which a person is convicted of violating these provisions, the court may require him or her to receive appropriate counseling as a condition of probation. A defendant ordered to be placed in a counseling program shall be responsible for paying the expense of his or her participation in the counseling program as determined by the court. The court shall take into consideration the ability of the defendant to pay, and no defendant shall be denied probation because of his or her inability to pay.

(l) Upon conviction for a violation of subdivision (b), (c), (d), (e), or (f), the sentencing court shall also consider issuing an order restraining the defendant from any contact with the victim, which may be valid for up to 10 years, as determined by the court. It is the intent of the Legislature that the length of any restraining order be based upon the seriousness of the facts

before the court, the probability of future violations, and the safety of the victim and his or her immediate family. This protective order may be issued by the court whether the defendant is sentenced to state prison or county jail, or if imposition of sentence is suspended and the defendant is placed on probation.

California Penal Code, section 368.5

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=368.5.&lawCode=PEN **PART 1. OF CRIMES AND PUNISHMENTS [25 - 680.4]** *(Part 1 enacted 1872.)* **TITLE 9. OF CRIMES AGAINST THE PERSON INVOLVING SEXUAL ASSAULT, AND CRIMES AGAINST PUBLIC DECENCY AND GOOD MORALS [261 - 368.7]** *(Heading of Title 9 amended by Stats. 1982, Ch. 1111, Sec. 2.)* **CHAPTER 13. Crimes Against Elders, Dependent Adults, and Persons with Disabilities [368 - 368.7]** *(Chapter 13 heading added by Stats. 2010, Ch. 617, Sec. 2.)*

(a) Local law enforcement agencies and state law enforcement agencies with jurisdiction have concurrent jurisdiction to investigate elder and dependent adult abuse and all other crimes against elder victims and victims with disabilities.

(b) Adult protective services agencies and local long-term care ombudsman programs also have jurisdiction within their statutory authority to investigate elder and dependent adult abuse and criminal neglect, and may assist local law enforcement agencies in criminal investigations at the law enforcement agencies' request, if consistent with federal law; however, law enforcement agencies retain exclusive responsibility for criminal investigations, notwithstanding any law to the contrary.

(c) (1) Every local law enforcement agency shall, when the agency next undertakes the policy revision process, revise or include in the portion of its policy manual relating to elder and dependent adult abuse, if that policy manual exists, the following information:

(A) The elements of the offense specified in subdivision (c) of Section 368.

(B) The elements of the offense specified in subdivision (f) of Section 368.

(C) The requirement, pursuant to subdivisions (a) and (b), that law enforcement agencies have the responsibility for criminal investigations of elder and dependent adult abuse and criminal neglect; however, adult protective services agencies and long-term care ombudsman programs have authority to investigate incidents of elder and dependent adult abuse and

neglect and may, if requested and consistent with federal law, assist law enforcement agencies with criminal investigations.

(D) As a guideline to investigators and first responders, the definition of elder and dependent adult abuse provided by the Department of Justice in its policy and procedures manual, dated March 2015, which defines elder and dependent adult abuse as "physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering; or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering."

(2) As used in this subdivision, the following terms have the following meanings:

(A) "Local law enforcement agency" means every municipal police department and county sheriffs' department.

(B) "Policy manual" means any general orders, patrol manual, duty manual, or other written document or collection of documents that provides field or investigative personnel with policies, procedures, or guidelines for responding to or investigating crimes, complaints, or incidents.

(Amended by Stats. 2019, Ch. 641, Sec. 2. (SB 338) Effective January 1, 2020.)

California – Welfare & Institutions Code § 15610-15610.65

http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=15001-16000&file=15610-15610.70

15610.05- "Abandonment" means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

15610.07.-(a) "Abuse of an elder or a dependent adult" means any of the following:

(1) Physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.

(2) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

(3) Financial abuse, as defined in Section 15610.30.

(b) This section shall become operative on July 1, 2016.

15610.39- "Imminent danger" means a substantial probability that an elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his or her own action or inaction, or as a result of the action or inaction of another person.

15610.43- (a) "Isolation" means any of the following:

(1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls.

(2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.

(3) False imprisonment, as defined in Section 236 of the Penal Code.

(4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors.

(b) The acts set forth in subdivision (a) shall be subject to a rebuttable presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician and surgeon licensed to practice medicine in the state, who is caring for the elder or dependent adult at the time the instructions are given, and who gives the instructions as part of his or her medical care.

(c) The acts set forth in subdivision (a) shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.

15610.57. -(a) "Neglect" means either of the following:

(1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

(2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise.

(b) Neglect includes, but is not limited to, all of the following:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

(2) Failure to provide medical care for physical and mental health needs. A person shall not be deemed neglected or abused for the sole reason that the person voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(3) Failure to protect from health and safety hazards.

(4) Failure to prevent malnutrition or dehydration.

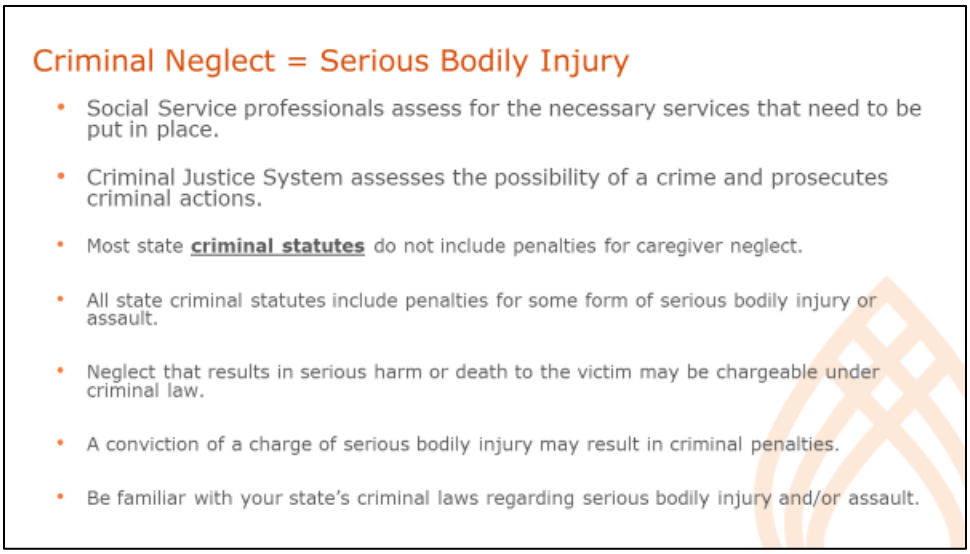
(5) Substantial inability or failure of an elder or dependent adult to manage their own finances

(6) Failure of an elder or dependent adult to satisfy any of the needs specified in paragraphs (1) to (5), inclusive, for themselves as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

(c) Neglect includes being homeless if the elder or dependent adult is also unable to meet any of the needs specified in paragraphs (1) to (5), inclusive, of subdivision (b).

15610.67.-"Serious bodily injury" means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation.

Slide #13: Criminal Neglect = Serious Bodily Injury



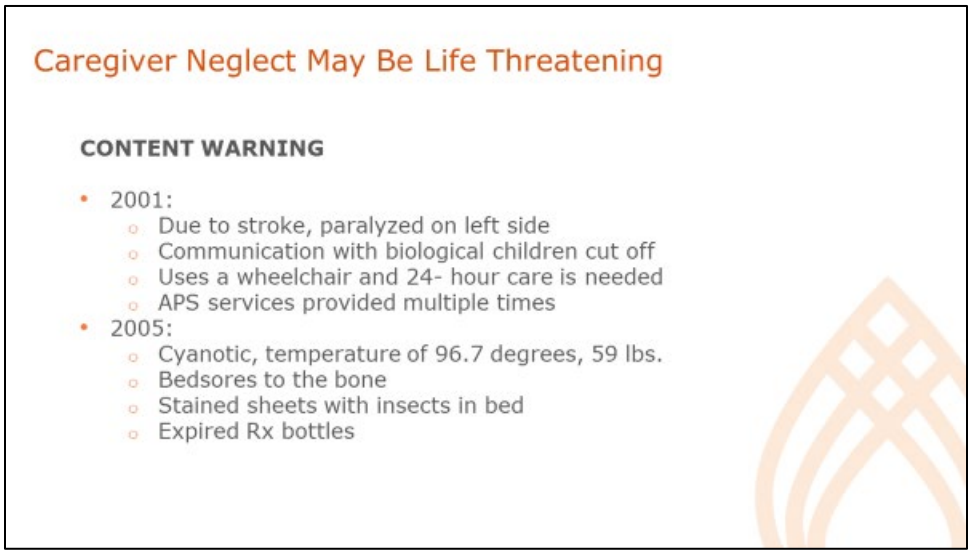
Review the slide and **explain** that APS and the Criminal Justice System (CJS) have some similar duties, but do have different purposes.

Discuss the following:

- As APS professionals, your job is to assess the client's situation in order to arrange for the necessary services to keep them safe.
- While the California WIC code uses the term "Serious Bodily Injury", the California Penal Code (section 12022.7(f)) uses the term "Great Bodily Injury". Whatever words are used to describe this type of injury, any apparent injury of this magnitude will necessitate the involvement of law enforcement.
- The role of the CJS is to assess the situation to determine if a crime has been committed, and if so, if criminal charges can be filed, and then prosecution initiated.
- While many state criminal statutes do not identify caregiver neglect as a chargeable crime, all states' criminal statues include some variation of "serious bodily injury" or "criminal negligence" as chargeable offenses.
    - Therefore, what APS defines as "caregiver neglect," may and should be chargeable under criminal law if it results in serious harm or death to the client.
- If charges are filed, there is the possibility that the neglectful caregiver/alleged perpetrator may be convicted of a crime and sentenced. While this may not be the outcome that the client desires, sometimes it is the only way to assure their safety. Be familiar with your state's criminal laws regarding serious bodily injury and prepare yourself and your client to be involved in a criminal investigation and the full legal process that may follow.

Slide #14: Caregiver Neglect May Be Life Threatening

Trainer Note: This slide is animated to first show a content warning and then a prompt for the activity.



<u>Activity #3- Case of the 59-pound Victim- Part 1 (5-10 min)</u>
Large group

Let us **review** this case study.
Instructions:

1. **Share** that we're going to review a case scenario that is extremely graphic and may activate some feelings. **Encourage** participants to do what they need to do to take care of themselves, even if that means stepping away.
2. Refer to **Case Scenario** in their participant manual.
3. **Ask** for different volunteers to read a paragraph out loud.
4. Once finished, **ask** participants if they know what "cyanotic" is?
   The term is defined as "turning blue" because a lack of oxygen.
5. **Ask** participants what does the body temperature of 96.7 tell them?
   The body temperature is low.

End by **telling** participants that later in the afternoon we will be **revisiting** this real case and how this case unfolded during our service planning session.

Case Scenario:
In 2001, a woman, living with her husband and two adult stepchildren, had a stroke and was paralyzed on her left side. She had two biological children, but after her paralysis, communication with them was soon cut off.
The woman was the primary source of income for her family. As a result of the stroke, she required the use of a wheelchair, and 24-hour care. Many

outpatient services were provided after her discharge from the rehabilitation hospital.

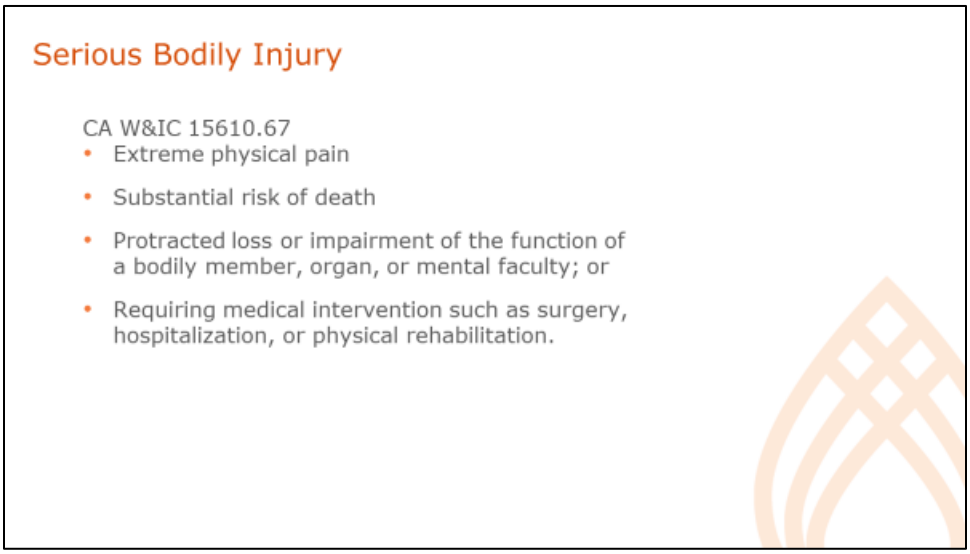
In the next four years, Adult Protective Services (APS) received numerous reports concerning the care that the woman was receiving from her family. Each allegation was investigated, and services were offered by APS. Each time services were put in place they were then discontinued by the husband or the victim, who was found to be competent at the time.

In 2005, the woman was taken to a local emergency department by her stepdaughter. She was slumped in her wheelchair, *cyanotic*, her temperature was 96.7 and she weighed 59 pounds. She had bedsores, one to the bone. She was foul-smelling and had excrement under her nails, in her mouth, on her torso, and on her lower extremities. Her husband had her health care proxy but refused to provide financial information so that she could qualify for benefits.

In the home where the victim had been living, investigators found stained sheets and insects in her bed. The husband was asked what the victim ate on a daily basis; none of the items he named were found in the home. He said that the victim "did not like to eat." He was asked what was being used to treat the bedsores and asked to produce these supplies, but none were located in the home. None of the victim's prescribed medications were current; there were only expired bottles.

Surprisingly, she survived and later we will revisit the final outcome.

Slide #16: Serious Bodily Injury



Review the points on the slide from California's Welfare & Institutions Code.

Explain that while every state's criminal statutes define serious bodily injury differently, they usually include the language from the slide.

These statements provide a baseline of descriptors that show the impact on victims of serious bodily injury.

- It is important that APS professionals be familiar with their own state's criminal definitions of serious bodily injury.
- Depending on your state laws, law enforcement and the legal system may or may not routinely get involved in situations of caregiver neglect.
- However, there are times when the extent of harm to the victim can have life threatening or lethal results.
- As an APS professional, your job is to identify various forms of mistreatment including caregiver neglect, assess the risk to the person, and arrange for the provision of services to prevent further neglect.
- You do not have the authority to hold a neglectful caregiver responsible for their actions. That is the role of the Criminal Justice System. However, your professional assessment and description of the harm done to the person can influence the outcome of the law enforcement response.

The phrase "serious bodily injury" is a legal term. Be familiar with your state's criminal statutes, so that you know how to present the harm that has occurred to a victim due to caregiver neglect in words that are familiar to

law enforcement, and that convey the seriousness and possible criminal implications of the neglect.

- Doing so effectively may increase the result in criminal charges and possibly a conviction that can serve as accountability of the perpetrator and prevention of further harm to client or others.

Note: Refer back to Handout #01 – State Statute and to Activity #03 – The Case of the 59-lb. Victim to demonstrate how some cases of caregiver neglect will involve issues with serious bodily injuries.

Slide #17: Working with Law Enforcement

Trainer Note: This slide is animated to first review the points, provide a content warning of the graphic, and then display the graphic.

Review the slide.

Using the Case of the 59-lb victim, here is an example of some language that may have been used with working with law enforcement.

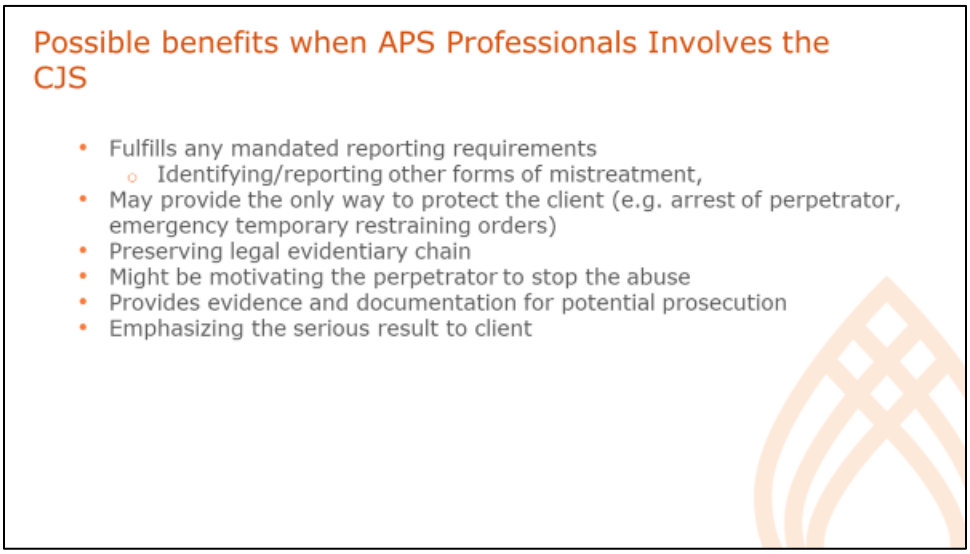
"I am calling to report an emergency and possible crime. The victim is acutely ill and apparently seriously injured. This is an immediately life-threatening situation. She needs emergency medical treatment right away."

Explain you are about to display the picture of the real 59-lb victim and it's extremely graphic. **Provide** a moment for participants to step away or do what they need to in order to feel comfortable prior to showing graphic.

Display the picture and **ask** participants to use language from their State's Statutes, language from Serious Bodily Injury, the case scenario and what they see on this picture to describe their observations in their case file and/or on a report, conversation or phone call to law enforcement to express the seriousness of the situation. Detailed documentation in case files is important for many reasons, one of which is case files may be turned over to law enforcement when it's legal and appropriate to do so.

Trainer Note: Ensure participants use some of the following: severity (size, color, look) of bed sore, emaciated, urine soaked, dirt on skin, body temp, barely breathing.

Slide #18: Possible benefits when APS Professionals Involves the CJS



Review slide which shares some reasons why APS should consider involving the Criminal Justice System.

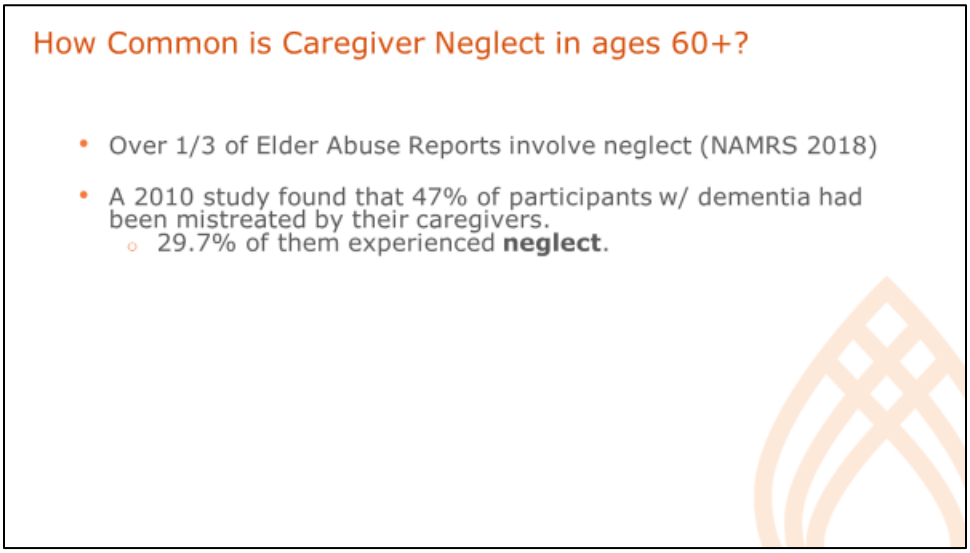
- Fulfills any mandated reporting requirements
    - Identifying/reporting other forms of mistreatment,
- May provide the only way to protect the client (e.g. arrest of perpetrator, emergency temporary restraining orders)
- Preserving legal evidentiary chain
- Might be motivating the perpetrator to stop the abuse
- Provides evidence and documentation for potential prosecution
- Emphasizing the serious result to client

In the Case of the 59-lb. Victim, it shows how important it is to include the legal system in caregiver neglect cases and to be familiar with the Criminal Justice System.

Ask, "What items would be important in regard to preserving legal evidentiary chain?"

Possible answers: bed linens, clothing, medications, soiled bandages, documentation, medical reports, etc.

Slide #20: How Common is Caregiver Neglect?



Read the statistics and **ask** if any of the statistics surprise them? And, why?

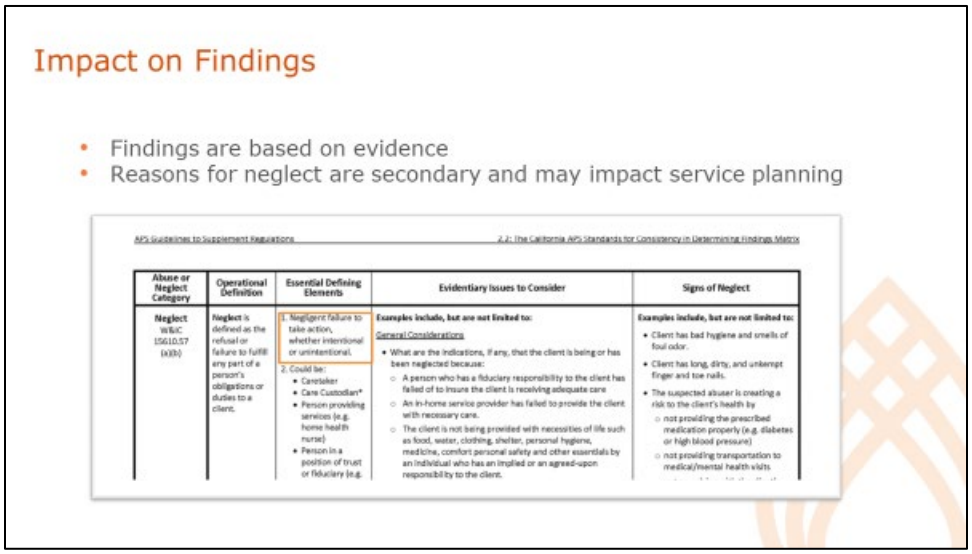
Cases of caregiver neglect are obviously a large portion of the allegations which APS investigates.

Explain that given the statistics, APS should be prepared for caregiver neglect, even when the initial allegation may sound like something else.

NEGLECT DYNAMICS AND CONSIDERATIONS FOR APS
Time Allotted: (40-45 MIN)

Slide #19: Impact on Findings

Trainer Note: Image on slide is from the CA Consistency in Determining Findings Matrix. If training outside of CA, replace with an image that is best for the area you're training in.



Explain that in this section, we will review some potential causes for, or underlying dynamics behind caregiver neglect.

It is <u>crucial</u> for APS staff to remember that whatever the reasons for neglect are, if the elements of neglect are present in the investigation and evidence found, the APS professional must confirm or substantiate it according to state statute and program policy and work to provide a collaborative service plan for the safety and well-being of the client.

- The reasons for neglect are secondary, and should not influence the findings.
- Exploring potential reasons for neglect is relevant for service planning, so we address them in this training, however, the reasons for neglect, or any sympathy that the investigator may feel toward the alleged perpetrator should not change the decision of the allegation finding.

Slide #20: Theories-Situational

A number of theories have evolved regarding why caregiver neglect occurs. While neglect is a failure of someone with a duty to act (caretaker) to fulfill that obligation to provide care resulting in harm, there are a variety of reasons a caregiver may neglect their duties. It is important to gather information about the reasons for the failure to act to guide the development of a service plan.

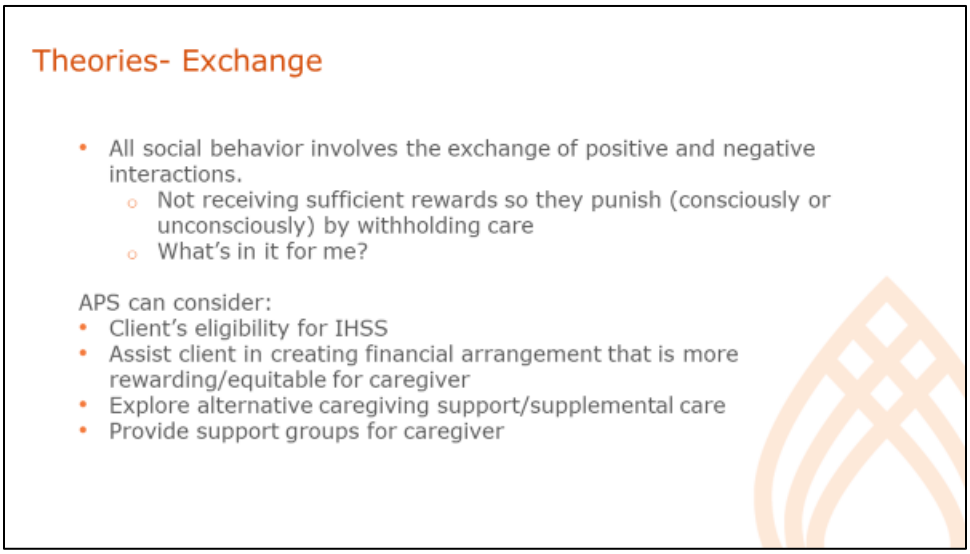
We'll review a few of these theories and dynamics, how this might present in APS investigations and potential impacts on service planning.

- ***Situational***: There are times when a caregiver is juggling the needs of the person they're providing care for, a personal crisis such as divorce, financial problems and health problems of their own. According to one study, the average length of time spent on care giving is about eight years, and one third of caregivers provided care for more than ten years. Many life changes that impact the caregiver and the victim may occur over time.

In these circumstances, when the caregiver is overwhelmed by other life happenings:

- APS should consider if the caregiver is by default because of cultural expectations or other influences.
- Explore what are the other demands?
- Is there any assistance available to help caregiver, if caregiver wishes to provide care? Is caregiver aware of that service?

Slide #21: Theories- Exchange



- ***Exchange theory***: All social behavior involves the exchange of positive (rewards) and negative (punishments) interactions. In situations of older and adults with disabilities abuse, the perpetrator may feel that they are not receiving sufficient rewards (affection, praise, money or goods) for the work being done, so they punish (consciously or unconsciously) the victim by withholding care. When rewards no longer feel sufficient to balance sacrifices, the caregiver may question, "Why am I doing this? What's in it for me?"

This can lead to the caregiver not providing (proper) care but still live off care recipient's assets, driven by sense of entitlement or disposition toward care recipient.

In these circumstances, when the caregiver doesn't feel they are receiving sufficient rewards, APS can consider the following:

- Explore client's eligibility for IHSS (In- Home Supportive Services) and refer the client to IHSS (with client's agreement) if eligible so that the caregiver can be formally paid for providing care.
- Assist the client in creating a financial arrangement with the caregiver that is fairer, rewarding, and/or equitable.
- Explore alternative caregiving options and/or supplemental care and respite.
- Depending on the client's care needs, help the client explore alternative care options, such as assisted living and/or placement (per the client's wishes).
- Provide referrals to the caregiver for caregiver support groups and other supportive services.

Slide #22: Theories-Social Learning

- ***Social learning***: a perpetrator may have been raised in an environment in which elders and people with disabilities were ignored and neglected.
- The way that the American public in general perceives older adults and adults with disabilities can contribute to caregiver neglect; both from an alleged perpetrator's learned behavior and when it comes to others, including the care recipient, taking reports of this allegation seriously.

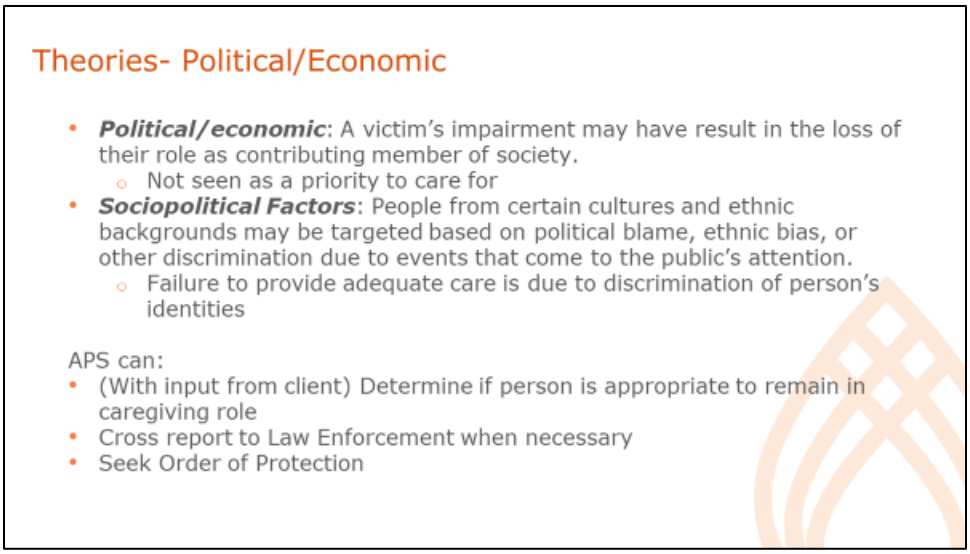
Share the following information on Ageism and Ableism:

- The National Center on Elder Abuse (NCEA) research brief on Ageism highlights:
  - "Ageism is defined as the stereotyping, prejudice, and/or discrimination of individuals on the basis of their age."
  - "Age prejudice has been found to be a risk factor for elder abuse. The adoption, endorsement, and activation of ageist stereotypes can lead to discriminatory behaviors, including neglect, abandonment, and emotional, financial, and physical harms"

In circumstances like these, APS can:

- Listen for ageist or ablest comments and discuss how they might be contributing for the care/lack of provided
  - Identify ways to provide care that meets the needs of the client
- Discuss culturally responsive care alternatives including supplemental care

Slide #23: Theories- Political/Economic



- ***Political/economic***: A victim's impairment may have result in the loss of their role as contributing member of society.

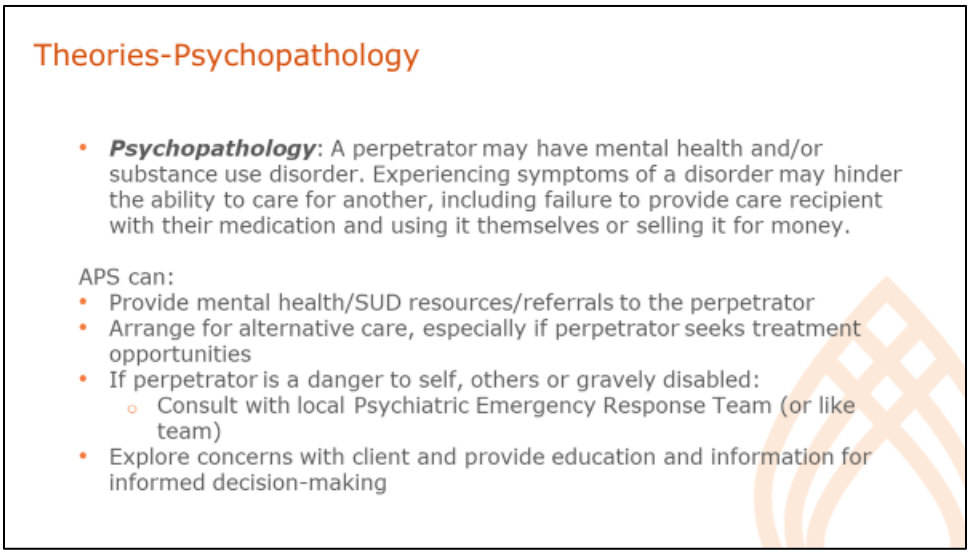
- ***Sociopolitical Factors***: People from certain cultures and ethnic backgrounds may be targeted based on political blame, ethnic bias, or other discrimination due to events that come to the public's attention. (Example: According to an article written in the Associated Press, August 12, 2021, discrimination and racially motivated violence against those from Asian cultures stemming from COVID-19 Pandemic. Caregiver starts neglecting care recipient in a retaliatory effort, blaming China or other Asian countries for "causing" the pandemic.)

- In circumstances where the care recipient is experiencing neglect due to potential racism, sexist, homophobic beliefs and behaviors from the caregiver, APS can:

    - With input from the client determine if this person is appropriate to remain in the caregiving role and if they can continue to provide care or not
    - If the neglect is criminal, cross-report to Law Enforcement (LE) and consult with LE about ways to remove the caregiver. Arrest (if neglect is criminal)? Protection Order

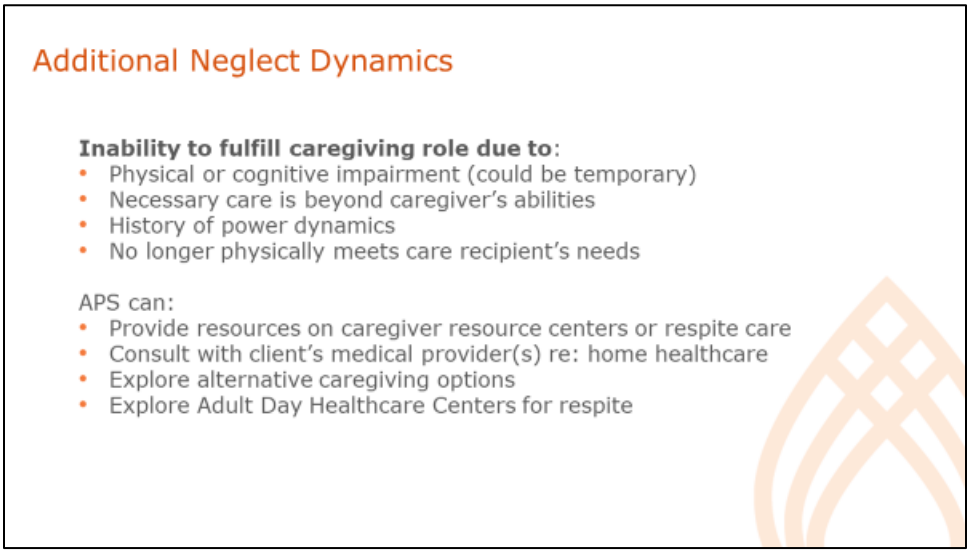
- Depending on the level of risk/danger, explore if the client is willing to pursue a restraining order against the caregiver.
- In cases where a client lacks decision-making capacity and is being neglected, explore the options of consulting with an appropriate legally designated decision maker (not the abuser)- such as DPOA, etc., conservatorship and/or an APS initiated restraining order.

Slide #24: Theories-Psychopathology



- ***Psychopathology***: A perpetrator may have mental health and/or substance use disorder. Experiencing symptoms of a disorder may hinder the ability to care for another, including failure to provide the care recipient with their medication and using it themselves or selling it for money.
- In these circumstances, APS might:
    - Provide resources/referrals to the perpetrator for substance use disorder treatment and/or mental health treatment. Offer to help arrange alternative care for client if the perpetrator agrees to treatment and this interferes with caregiving duties. For example, if the perpetrator enters in-patient Substance Use Disorder (SUD) treatment.
    - If appropriate, refer the perpetrator to a local mental health outreach organization whose role is to connect people experiencing mental health concerns with appropriate mental health services.
    - If available, consult with the Psychiatric Emergency Response Team (PERT), or like team, if the perpetrator is a danger to self or others, and/or gravely disabled.
    - Explore the concerns with the client and provide information and education so that the client can make a more educated and informed decision about whether or not to have the perpetrator remain in the caregiving role.

Slide #25: Additional Neglect Dynamics



Share APS should keep the following dynamics in mind when investigating whether or not someone is neglecting to provide care.

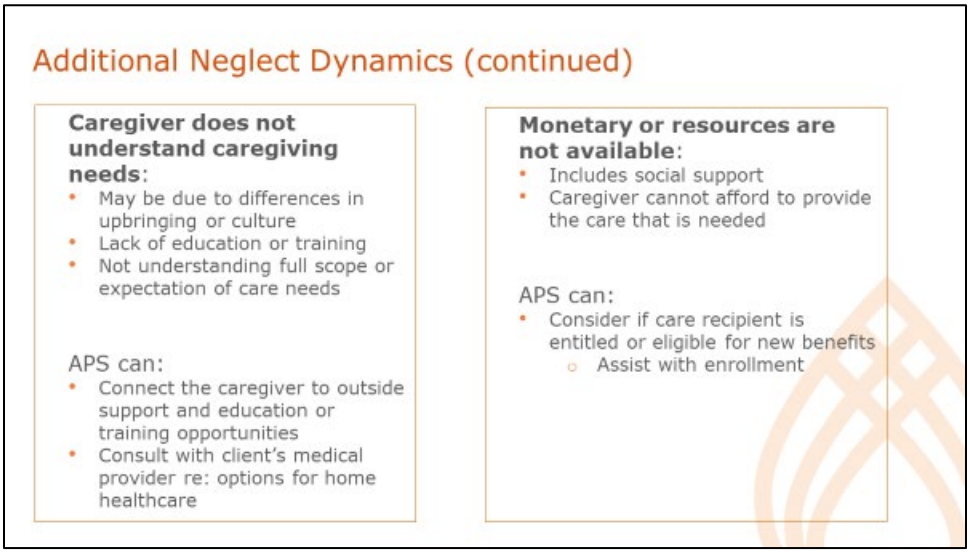
The caregiver is **unable to fulfill caregiving role**—they are doing the best they can, and still neglecting their duties as a caregiver. Examples:

- Caregiver is a person with physical or cognitive impairment that makes it impossible to provide needed care
    - This may be temporary: (example: caregiver is invested in caregiving, but is undergoing chemotherapy themselves. There might be times they are physically not strong enough to provide proper care).
    - The caregiver's sight may have declined and can no longer read instructions or sort out medications.
- The necessary care is far beyond abilities of caregiver
- The caregiver has always been dominated by care recipient who has history of refusing care.
- The caregiver can no longer physically meet the needs of the care recipient
    - For example, the caregiver can no longer lift the care recipient or are experiencing their own challenges with balance and mobility

In these circumstances, APS might:

- Connect both the client and caregiver with a caregiver resource center and/or respite care.
- Consult with the client's medical provider to see if the client can receive home healthcare services covered by insurance.
- Help the client explore alternative caregiving options.
- Explore Adult Day Healthcare Center options to provide respite and support.

Slide #26: Additional Neglect Dynamics (continued)



The caregiver **does not understand caregiving needs** of client but wants to provide care.

- This may be due to differences in upbringing or culture(s), lack of education or training, or even not understanding the full scope or expectation of care needs.
    - An example could be that the caregiver is an adult child who has a developmental disability and was never taught independent living skills. They are now responsible for taking care of their parent or guardian but don't understand what it requires.

In these circumstances, this type of caregiver may benefit from education or training and APS might:

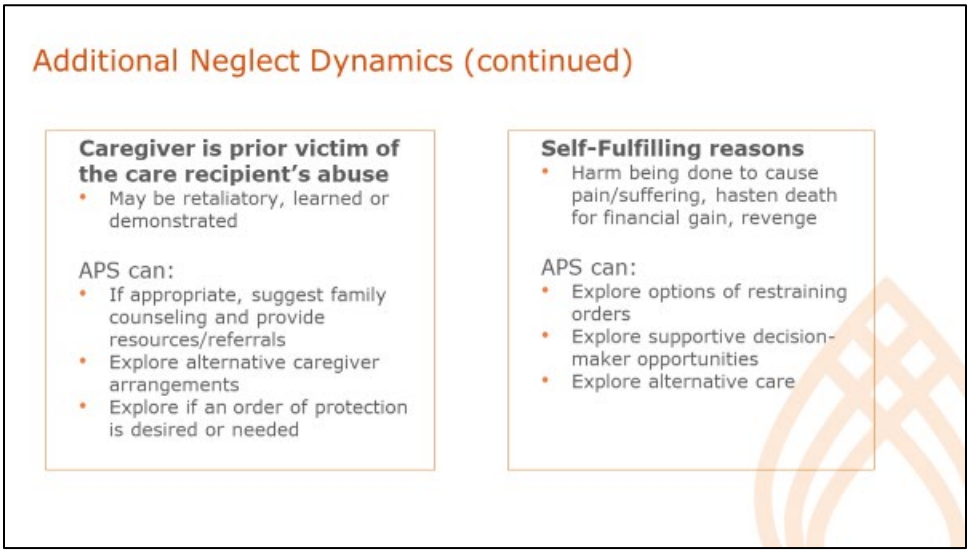
- Connect the caregiver with caregiver support and education.
- Consult with client's medical provider to see if Home Healthcare Services can be provided, which can include caregiver support, medical equipment/ supplies, instruction, and education.

Monetary or resources, including social support, are not available-the caregiver cannot afford to provide the care that the recipient needs. There is no evidence of financial abuse or misuse but costs far exceed available funds.

In this circumstance, APS might:

- Consider if care recipient is entitled or eligible for new benefits (and can APS assist with enrollment).
    - Veteran status, including spouse of a Veteran means they may be eligible for VA Aid and Attendance
    - IHSS
    - Other community or non-profit organizations

Slide #27: Additional Neglect Dynamics (continued)



The caregiver is **prior victim of the care recipient's abuse**. The neglect may be retaliatory or what was learned and demonstrated growing up.

In the circumstance, APS may:

- If appropriate, suggest family counseling and provide resources and/or referrals. Note: couples counseling is contraindicated in cases of Domestic Violence when power and control dynamics are present.
- Explore alternative caregiver arrangements and/or respite care. Giving the caregiver a break (respite) from care may ease tensions in the situation.
- Depending on the level of risk/harm, explore if the client would like to pursue a restraining order.

There may be **self-fulfilling reasons** as well that must be considered.

- For example: is the neglect being done to harm the older person (to cause pain and/or suffering, to hasten death for financial gain or other reasons, or for revenge).

In these circumstances, APS may:

- Explore the option of restraining order with client, depending on the level of risk/danger.

- If the client lacks decision-making ability regarding their own safety, explore the following options:
    - Is there an appointed decision maker (not the abuser) who can be consulted with to make the situation safer?
    - Explore the option of an APS- initiated restraining order, depending on the level of risk/danger.
- Explore alternative care and/or placement options with the client, depending on their care needs.
- Explore the option of bringing in a home health agency or Hospice (if client is eligible) to help monitor client's care and safety.

Slide #28: Additional Neglect Dynamics

Role reversals may play a part in neglect as well.

- In some relationships, there becomes a role reversal where the person who has been providing care now also needs care. Some common situations where this might occur:
  - The caregiver is living with a health condition and needs care based on the symptoms they experience,
  - The caregiver is living with a physical or developmental disability that they need care for
  - The caregiver has a substance use disorder and symptoms now require care.
- In these situations, the client, who was once the caregiver, now is the recipient of care. For some older, heterosexual couples, traditionally the wife may have cared for the husband. When she needs care, he may lack care-giving skills and/or resent her dependency. This can also be true from same-sex couples who have developed gender roles similar to those in heterosexual couples.

Other **Cultural and Social factors** may contribute to neglect.

- ***Interests of individual vs. community***: Sometimes the interest of the individual conflict with what is good for the community. As an

example, providing shelter to a family member who is older or unable to care for themselves is a strong traditional value in some cultures even though the individual may need a higher level of care than what a family member can manage. For instance, some rural areas of the United States, where resources are scarce and families may provide the older adult shelter, but either overmedicate the person or leave them alone for long periods of time.

- ***Demographics***: Income and education level, employment level, living arrangements, geographic location and housing conditions may play a significant role in caregiver neglect.
- ***Language barriers*:** Language barriers can raise complications, especially when either the client or the caregiver has limited fluency in the language that is dominant in that location. In addition, the way that various ethnic groups interpret language may result in different responses to the issue.

Culturally based perceptions and behavior should be taken into consideration in determining appropriate, culturally responsive interventions.

Summary for dynamics involved in caregiver neglect:

- The APS professional should gather the facts about the case first to develop an objective understanding of the situation, client's needs, and harm to date and into the future if the situation were to continue.
- Once that is done then the APS professional can consider what an appropriate intervention is.
- Understanding a caregiver's motivation may be helpful in deciding if a caregiver can and should continue to provide care, any augmentations that should be offered or added (e.g., education, visiting nurse, in home support), or whether a different caregiving arrangement is needed.
- Careful interviewing, along with input from a worker’s supervisor may yield significant information about caregiver strengths, weaknesses, and even motives, but the initial determination of neglect must be primary.

Slide #29: Identifying the Dynamics

<u>Activity #4: What Dynamics are Present? (10 min)</u>
Individual, Large Group

Instructions:

1. **Ask** participants to read the three short scenarios on **Handout #2** to themselves and decide if it meets caregiver neglect and if so, which theory or neglect dynamic might apply (may be multiple).
2. After 5 min, **ask** the entire group to shout out their answers and discuss any discrepancies.

Answers:

- Case Scenario 1- Samira:
  - Is this a case of caregiver neglect? *Answers: yes, situational and role reversal*
- Case Scenario 2- Joseph:
  - Is this caregiver neglect? *Answer: Yes, Monetary Resources, possible role reversal or psychopathology*
- Case Scenario 3- Joan
  - At this phase in the investigation, is Bob neglecting Joan? *Answer: Apparently not*

HANDOUT #2- Case Scenarios

Case Scenario 1: Samira

- You investigate alleged abuse of Samira A. by her daughter, Minna. Samira lives with brittle diabetes (meaning her blood sugars vary dangerously on short notice). When you talk with Samira, her daughter is not home, and initially she describes her daughter as an excellent caregiver. Samira's doctor has stressed that her blood sugars must be checked and recorded daily and her insulin adjusted per a sliding scale or she could end up in the hospital again. You look at the recording sheet and it is blank for the last several days. When you ask how much insulin she got this morning she cannot tell you the dose. When you ask further about her diabetes and the care she gets from her daughter, she bursts into tears and tells you that her daughter has not checked her blood sugar for several days and that she has been guessing how much insulin to give herself. Samira sobs: "it's just that she and her boyfriend broke up and she has been out drinking with her friends a lot and sometimes does not come home to help me…but she's really a good girl, just having a hard time, please don't say anything.

Case Scenario 2: Joseph

- You investigate an allegation of neglect of Joseph M. whose doctor called in a report because Joseph has not been taking the heart medications required for their condition of Congestive Heart Failure. Joseph's son, Jules, is his caregiver. When you arrive to interview Joseph, Jules does not want to leave the room, eventually, on your persuasive suggestion, he does leave you alone with Joseph. When asked about not taking the heart medications Joseph says that he decided not to take them. Initially he is insistent that he has decided this, but when you continue to probe for answers, he finally blurts out: "we just don't have the money!". You discuss his income, his Medicare, and health insurance he receives from her previous employer, and it seems that he should be able to afford his medications. When you point this out he becomes defensive and says that he and his son have 'other expenses'. Discussing further, he discloses that his son is unable to find a job, and has no car insurance. He recently had an automobile accident "after having had a little too much to drink" and the man whose car he hit agreed not to report it if they paid him the balance over several months, the cost of repairs was over $3000. Joseph

explains that Jules has just "always had bad luck" and "can't hold a job" so they both have to live on his income. The co-pay for his heart medications are just too much to pay after making payments toward his son's accident. "He needs me" Joseph says, "and it's my decision".

Case Scenario 3- Joan

- Bob is Joan J's caregiver and her husband. A neighbor called in a report that he is not caring for her adequately. Joan had a leg amputated due to her diabetes six months ago and needs help with shopping, cooking, and bathing. When you arrive at home Joan is alone and she proceeds to tell you that her husband is not doing enough for her. She complains that the meals he makes do not taste good, that he does not bathe her well, requiring that she must bathe parts of herself, and that he does not talk with her enough leaving her lonely. During your interview with Joan, Bob comes home loaded down with groceries. He is a quiet man and seems surprised and embarrassed that you are there. Joan begins to berate him loudly asking, "Did you get the right kind of apples this time? Why did you take so long? Are you avoiding me again?" Bob answers her patiently, and apologizes profusely at her complaints. You speak to Bob alone and he tells you that he has been trying to learn what to do as a caregiver, but that according to his wife he just keeps failing. At your request he shows you what he has purchased and it appears appropriate. Asked about the care he gives Joan, he describes in detail his routine with her, and seems to be taking appropriate care with her. You go back to talk with Joan and verify all that Bob has been doing. She agrees with each caregiving step he has mentioned, but also finds some reason to criticize him.

RISK FACTORS AND RISK INDICATORS
Time Allotted: 50-60 minutes

Slide #30: Risk Factors vs. Risk Indicators

Before we explore risk factors further, it is important that we are able to differentiate between risk factors and risk indicators.

Risk Factors are conditions that put a person at risk of harm. If a risk factor is present, it increases the likelihood that abuse or neglect has already occurred or will occur in the future. Risk factors could also be called 'predictors'.

Risk Indicators are observable signs, things you can see or hear, that indicate that risk may be present. Indicators may be physical, behavioral, or environmental.

We briefly discussed theories and dynamics in the previous section, and some of the following risk factors may align with the theories identified.

Slide #31: Client Risk Factors

Review the risk factors listed on the slide and **remind** participants that these factors do not automatically equate to neglect is happening.

- Clients who are ***isolated*** are more vulnerable and may be reluctant or unable to complain about being neglected or to seek help

- Clients with ***limited mobility*** cannot get away from caregivers, often cannot leave the home, may have less communication with family and friends, and may be very dependent on their caregiver for toileting, bathing, changing clothing, etc.

- Clients who have ***difficulty communicating*** will have great difficulty telling anyone what is happening to them. They may be trapped in a world where only their caregiver is the only person communicating for them. If the caregiver is neglecting or abusing them, they will be able to cover for their neglect or abuse.

- Clients with ***memory impairments*** may have difficulty remembering what happened to them, or when. Due to their limited memory they may be unable to express what is happening, and unscrupulous persons may say that they are just confused or imagining things if they do try to communicate something negative that is happening to them.

- ***Distant or estranged family members*** will not be there to advocate for their family member's care or to evaluate the level of care they are receiving. Clients experiencing neglect or some other form of abuse may be reluctant to share this with estranged family members, or afraid of alienating distant family members.

- Clients that are ***dependent on others for their basic needs*** must rely on caregivers for all of their needs. Alienating the caregiver or complaining about them could result in retaliation or even more neglect. Clients that have **challenges with ADLs or IADLs** may have problems with toileting, bathing dressing, shopping or preparing meals, will have difficulty functioning independently and risk falling, infection, or other problems. These limitations make the client more dependent on others.

- **Untreated disease and/or a chronic illness** may limit the client's independence, make communication more difficult, and leave the client more vulnerable than if they were healthier.

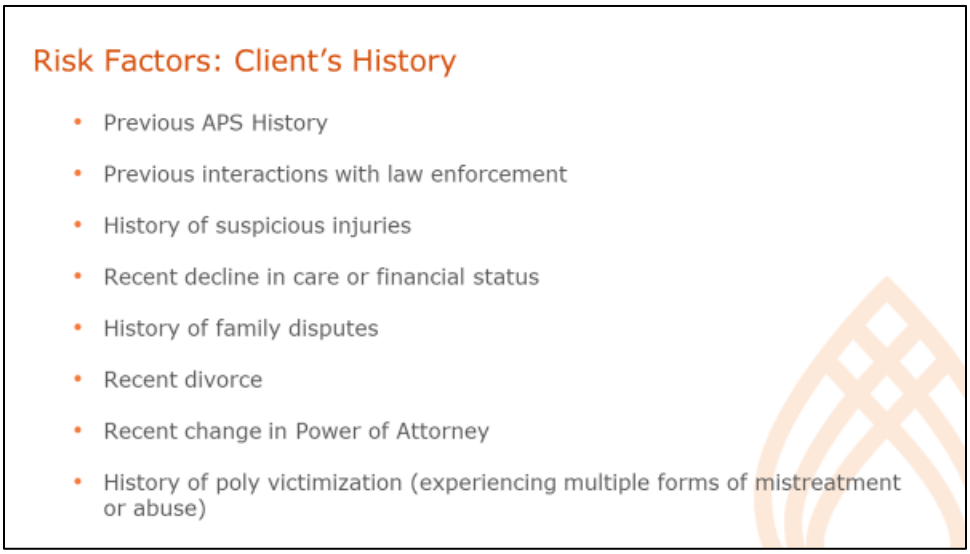
    - **Note**-To the extent that the caregiver is directly responsible for arranging for or providing care for medical conditions, this could be an indicator of neglect rather than just a factor increasing the risk of neglect.

- A client who is **disoriented** may lack awareness if they are being cared for properly or to communicate what is wrong. If they do raise a complaint, they may be unable to give details, and the neglectful caregiver may claim that they are 'just confused' or 'imagining' what they say happened or did not happen.

- If a client seems to clearly need an **assistive device**, i.e. a cane, a walker, shower or bath chair, or other durable medical equipment, they are at risk for falling or other injury. Some clients may just be reluctant to use assistive devices, however, they are placing themselves at additional risk.

Ask: "Have you encountered clients in these circumstances?" and "Is there anything missing from this list?"

Slide #32: Risk Factors: Client's History

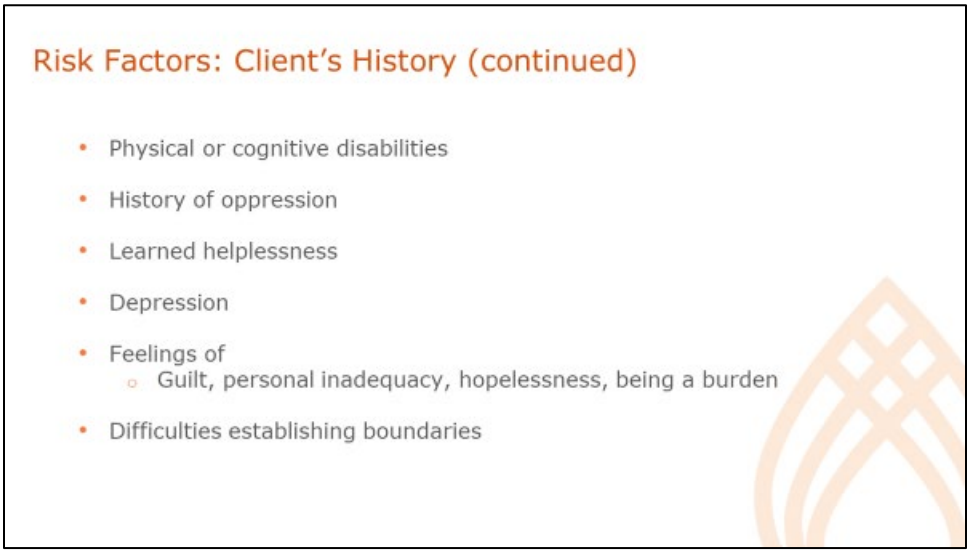


In addition to the circumstances just discussed a client's history can also put them at risk to be neglected by a caregiver. As discussed previously, these factors do not ***indicate*** that the client has been abused, but could be considered red flags that must be explored during the investigation.

Historical Factors to Consider:

- Previous APS History
- Previous interactions with law enforcement
- History of suspicious injuries
- Recent decline in care or financial status
- History of family disputes
- Recent divorce
- Recent change in Power of Attorney
- History of poly victimization (experiencing multiple forms of mistreatment or abuse)

Slide #33: Risk Factors: Client's history (Continued)



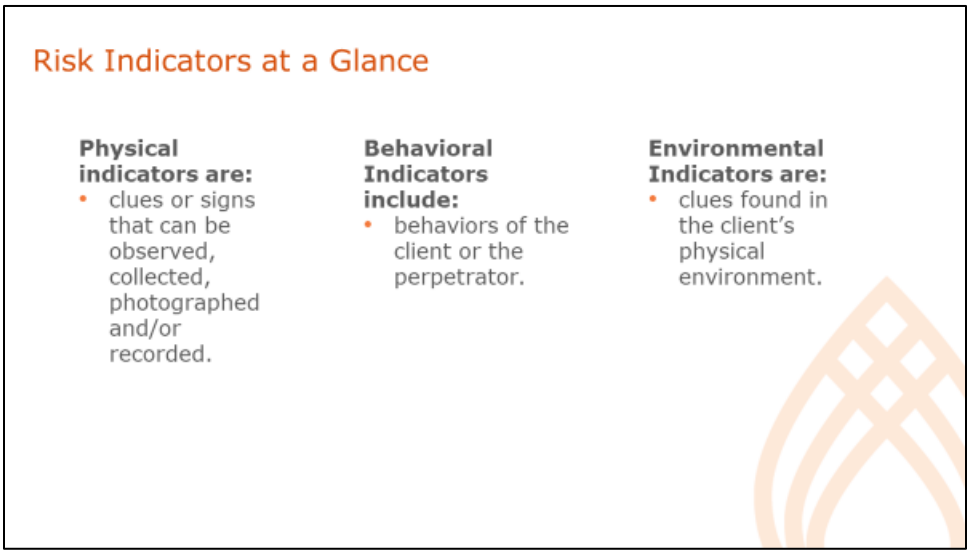
- Persons who have **physical or cognitive disabilities** are often victims of abuse or neglect as some may not be able to understand what is happening to them or to express their concerns. Others may perceive them as vulnerable and take advantage of that.
- Due to a lifetime **history of oppression** based on race, gender, disabilities, and/or culture, the client may not think that they are entitled to good care, or that the care they are receiving is all that they are entitled to.
- **Learned helplessness or depression** may limit the person's ability to advocate for themselves and share about the poor care.
- Sometimes feelings of **guilt, personal inadequacy, and hopelessness** mean that the client does not believe that the situation can get any better.
- And often the client does not want to be a **burden** on the caregiver. They may focus more on the perpetrator's needs than their own i.e.- he's been through so much, or… she gets so tired from having to help me with everything-I don't like to bother her or get her upset.
- History of **protecting the person** and **difficulty establishing boundaries**.

Ask: "What is Learned Helplessness?"

Possible answers:

- A pattern of behavior in which the client comes to feel that they cannot help themselves and are always under the control of others.
- The client feels unable or unwilling to make important decisions about their lives and feel that they must rely on others for this.

Slide #34: Risk Indicators at a Glance



Explain that an important aspect of an APS investigation is risk indicators, which are observable signs (physical, behavioral, and environmental) that indicate risk may be present. We will briefly cover types of indicators and then discuss more in depth on next few slides.

- **Physical indicators are clues or signs that can be observed, collected, photographed and/or recorded.**
    - Observable evidence, such as single or multiple bruises, wounds or injuries that are unexplained, or untreated. Signs of inadequate hygiene including soiled bedding that hasn't been changed. Medication missing or unfilled.
- **Behavioral Indicators include behaviors of the client or the perpetrator**.
    - These may include caregivers who seem resentful, angry or over-taxed by responsibilities and clients who seem fearful or make excuses for caregiver behavior. They may include what victims, perpetrators, and witnesses tell you, how they tell you, and the interactions between them.
- **Environmental Indicators are clues found in the client's physical environment.**
    - These may include a deteriorated home, lack of food, lack of amenities even though the older adult can afford them, signs of inappropriate restraints, such as locks on the outside of bedroom doors, etc. Are there low to moderate financial resources when there once was sufficient? Living arrangements shared with the

alleged perpetrator may be an indicator as well. Example: if the level of care is such that the caregiver should be providing supervision or assistance most/all of the time, are they?

Some risk factors can also present as risk indicators. For example, isolation is a risk factor (conditions that put someone at greater risk) but also can be an indicator that a caregiver is neglecting the person they are responsible for.

Remind participants to use all their senses when observing clients, particularly their sense of smell.

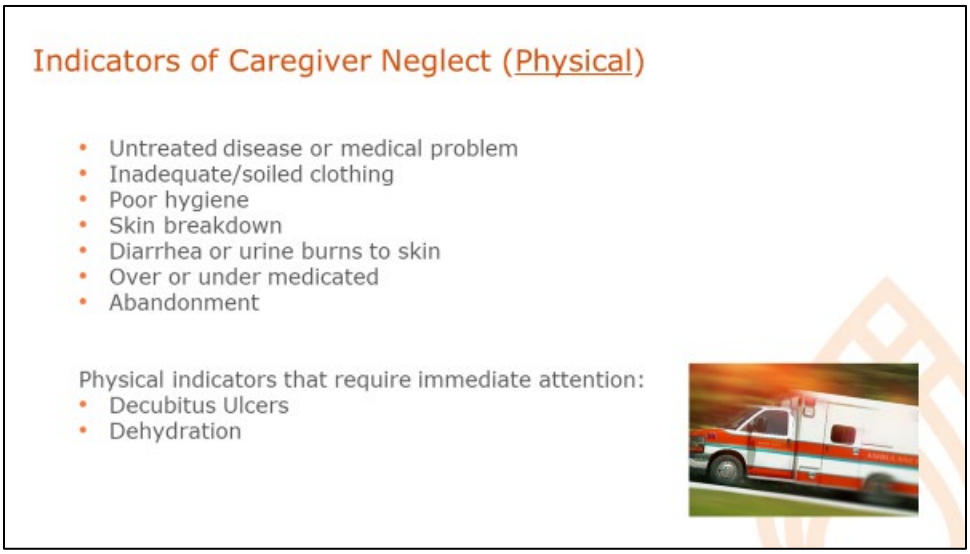
Ask: How would you go about using all your senses?

Possible responses:

- *Does the client appear dirty and unkempt?*
- *Are dates on medications current or expired?*
- *Do they have a foul odor?* ***APS professionals are encouraged (with client's permission) to lift bedclothes and/or clothing to observe the condition of the bedding and their skin condition, especially at pressure points such as the shoulder blades, elbows, buttocks, and back of heels.***
    - *If available, collaborate with APS Public Health Nurses to assist.*
- *Does the client appear feverish or chilled?*
- *Does the client lack dentures, eyeglasses, or other assistive devices?*
- *Are liquids and appropriate food available?* ***(ask for permission to check the refrigerator)***
- *Do you see trash or soiled floors, counters, or stacks of dirty dishes or food wrappers?*

Alternative Explanations. Alternative explanations must always be considered. It may be difficult to differentiate indicators from accidental injuries or the effects of illness. Neglect may also result from an older adult refusing help. Some clients may minimize or deny the neglect altogether.

Slide #35: Indicators of Caregiver Neglect (Physical)



Cover the following physical indicators that neglect may be occurring:

An **untreated disease or medical issue** could mean that the caregiver has been failing to oversee the client's medical or physical care and may not have been arranging for medical interventions like doctor's visits or failing to inform medical oversight staff of the client's condition. Of course, resistance on the client's part to treatment must be evaluated when this indicator is being considered as caregiver neglect.

Inadequate or soiled clothing or **poor hygiene** of the client's person may mean that the caregiver has not been attending **to** the client's hygiene, and/or failing to provide clean clothing for the client.

Skin breakdown may be evidence that the client has not been being turned, moved, or repositioned properly. Although skin breakdown may occur even when a client is being cared for, it must be addressed immediately, and the caregiver should be able to state when the breakdown began and exactly how it is being treated. Supplies for such treatment should be present, and the client's physician should have been notified.

Anyone may experience diarrhea, however, when **diarrhea or urine** have left reddened irritation or **burns** to the skin, it may mean that the caregiver has not been changing the client or addressing their bowel or incontinence problems.

Clients who are **over or under medicated** such as clients who are complaining of pain and have medication ordered specifically but are

not/have not been receiving it; or clients who appear very somnolent even during the day or cannot be roused to talk to despite having been clear mentally before may not be receiving medications as directed by their physicians. Reviewing the client's medication record and interviewing the client at different times of day (or under the care of alternate caregivers may prove useful in evaluating this possible form of physical neglect.

Share the following information about indicators that require immediate attention:

Although any type of caregiver neglect may have serious consequences for a client, the physical indicators listed above are always serious and may require immediate intervention if not being addressed.

Decubitus Ulcers are serious medical conditions that require specialized and intensive medical treatment. If deep enough, they may require surgery to heal. Complications of decubiti may include infection or even septicemia (an infection that has spread to the bloodstream) may occur, which can be life threatening.

Dehydration impacts all of the systems of the body and can be fatal. If a client is not drinking regularly, some type of record keeping or monitoring should be taking place. Clients that are not taking in regular fluids by mouth may require intravenous fluids that must also be carefully monitored and can only be given by specifically trained medical personnel.

Ask:

- What are some indicators of dehydration?
  Possible answers:
  - *Have the person pinch their skin.*
    - *Does it return back to normal or does it stay up (possible sign of dehydration)?*
  - *Ask the person how often they use the restroom or drink liquids.*

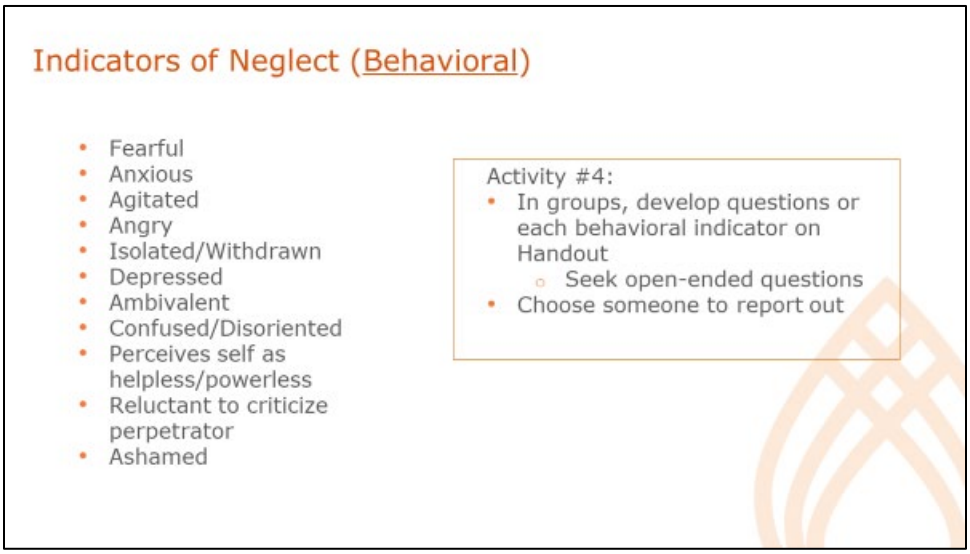
- What are some indicators of possible malnutrition?
- *Possible answers: May have sunken eyes, discoloration of the skin, oversized clothes, weight loss.*

Emphasize indicators listed that result in the person's lethargy or lack of responsiveness and may require an emergency intervention.

Such intervention includes calling 911 for an ambulance and/or police investigation or removing the client (with consent) to a safer environment such as a neighbor or a family member's or a friend's home.

APS staff should not move clients in medical distress. That is the responsibility of trained medical staff. APS staff must avoid liability both for themselves and for their programs. Aside from emergency interventions by trained APS staff such as CPR or basic first aid, medical professionals should provide all intervention. In addition, if it appears that a crime has been committed, law enforcement officers may need to see, document, and perhaps photograph or video record the scene of the incident.

Slide #36: Indicators of Neglect (Behavioral)



Explain that many clients who are victims of neglect do not verbally identify themselves as being neglected. APS professionals need to pay attention to the person's behavioral indicators, as well as physical manifestations of neglect discussed on the previous slide.

Review the following behaviors APS may observe that indicate possible neglect:

- Fearful, Anxious, Agitated, Angry, Isolated/Withdrawn, Depressed, Ambivalent, Confused/Disoriented, perceives self as helpless/powerless, Reluctant to criticize perpetrator, Ashamed

Ask: "How would a client appear fearful or ambivalent?"
Possible answers:
Fearful: They hesitate to talk openly, they keep checking over their shoulder during the interview.
Ambivalent: They makes contradictory statements, hesitate to give information or provide aloof answers.

Explain the importance of documenting these behavioral indicators as well as the physical ones.

Activity #5- Reponses to Behavioral Indicators (20-25 min with report out)

Breakout groups

- **Refer** participants to **Handout #03 – Responses to Behavioral Indicators** in their manuals.

- **Instruct** participants to work in small groups for 10-15 minutes and develop 2-3 questions they would ask clients for each behavioral indicator on Handout #3 to determine if what APS is observing is actually what is happening. The purpose of this is to allow participants to explore these indicators in depth in their assessment for possible abuse or neglect and to aid in service planning.
    - Try to avoid questions for clients that would result in for "Yes" or "No" answers.

Report Out: For each indicator, **ask** a group to share one of their questions. **Invite** other groups to provide an additional question that they believe might address the behavior differently. Move through all of the groups as time allows.

Trainer Note: APS professionals have expressed the desire to have various examples of asking good, open-ended questions. This "round robin", provides the opportunity for them to get a variety of questions to adapt to their own style.

Some example questions are listed below for each behavioral indicator, use these to supplement participant questions.

1. The client appears fearful and reluctant to talk openly about the situation.
   Possible responses:
   a) *How can people offer you the right kind of support?*
   b) *Where do you think I can fit into the picture?*
   c) *How do you decide what to worry about?*
   d) *What happens when you don't know whom you can trust?*
   e) *What's your approach to things you don't particularly want to deal with?*
2. The client's demeanor changed when the caregiver enters the room (after caregiver leaves ask following questions)
   Possible responses:
   a) *What happens when you have to deal with a person's behavior that you don't understand?*
   b) *What are some of the things about relationships you wish could be different?*
   c) *Tell me about your relationship with your caregiver.*
   d) *If you have any concerns about your care, can you please share with me?*

3. The client seems isolated and withdrawn – turning away from contact.
   Possible responses:
   a) *How does a person go about reassuring you?*
   b) *What happens when you worry?*
   c) *What would help you feel safe to discuss difficult topics?*
   d) *I would like for you to feel that you can trust me. What do you need from me in order for that to happen?*
4. The client appears hopeless – exhibiting flat affect.
   Possible responses:
   a) *What do you think would improve your situation?*
   b) *What would make you feel more hopeful about your situation?*
   c) *What is the best way to approach something you'd rather not talk about?*
   d) *What, if anything, keeps you from openly voicing your concerns?*
5. The client acts indecisive, ambivalent – makes contradictory statements and decisions.
   Possible responses:
   a) *How much can you depend on the people around you?*
   b) *What are some things you'd like to change?*
   c) *What have we left out of the picture, so far?*
   d) *What steps are you willing to commit to and what do you want to do first?*
   e) *What kind of support do you need to move forward/achieve safety?*
6. The client appears confused or disoriented.
   Possible answers:
   a) *Please tell me your name.*
   b) *Where are we right now?*
   c) *Who is taking care of you?*
7. The client is reluctant to criticize the perpetrator or complain about lack of care.
   Possible answers:
   a) *How are we going to talk about things that don't seem to be working the way we hoped?*
   b) *How do you know when to let a person know what you are really thinking?*
   c) *How do you know when a situation is beginning to become too hard to handle yourself?*

Handout #3- Responses to Behavioral Indicators

- The client appears fearful and reluctant to talk openly about the situation.
  Possible responses:

- The client's demeanor changed when the caregiver enters the room (after caregiver leaves ask following questions)
  Possible responses:

- The client seems isolated and withdrawn – turning away from contact.
  Possible responses:

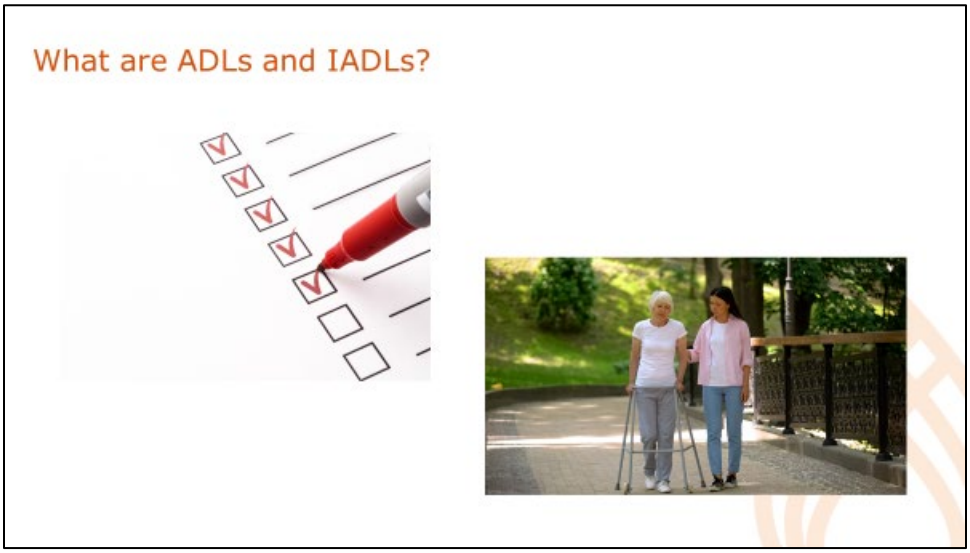
- The client appears hopeless – exhibiting flat affect.
  Possible responses:

- The client acts indecisive, ambivalent – makes contradictory statements and decisions.
  Possible responses:

- The client appears confused or disoriented.
  Possible answers:

- The client is reluctant to criticize the perpetrator or complain about lack of care.

Slide #37: What are ADLs and IADLs?



Refer participants to **Handout #04 – ADL's/IADL's** in their participant manual.

Here is a checklist of activities of daily living and instrumental activities of daily living. The fewer activities a person can do for themselves, the more dependent that person is on the caregiver.

It is important to talk with the client and the alleged perpetrator separately, asking each of them the extent of the client's ability or inability to care for themselves, and what specific activities the caregiver/alleged perpetrator is doing to assist with these limitations. Talking with the client and the caregiver separately may result in very different stories about what is and is not being done.

For example, ask the client what they like to eat, what food is actually provided and how often it is provided. Then ask the caregiver the same questions and see if the answers are similar. Check in the cupboards and the refrigerator to see if the food is actually available.

If you have doubts about how the client or the caregiver performs a specific task, ask them to demonstrate how they do it.

Handout #04: ADLS and IADLs Checklist

Client: _____

ADLs	***Independent***	***Needs Assistance***	***Cannot Perform***
Bathing	○	○	○
Dressing	○	○	○
Eating	○	○	○
Transferring	○	○	○
Assistive Walking	○	○	○

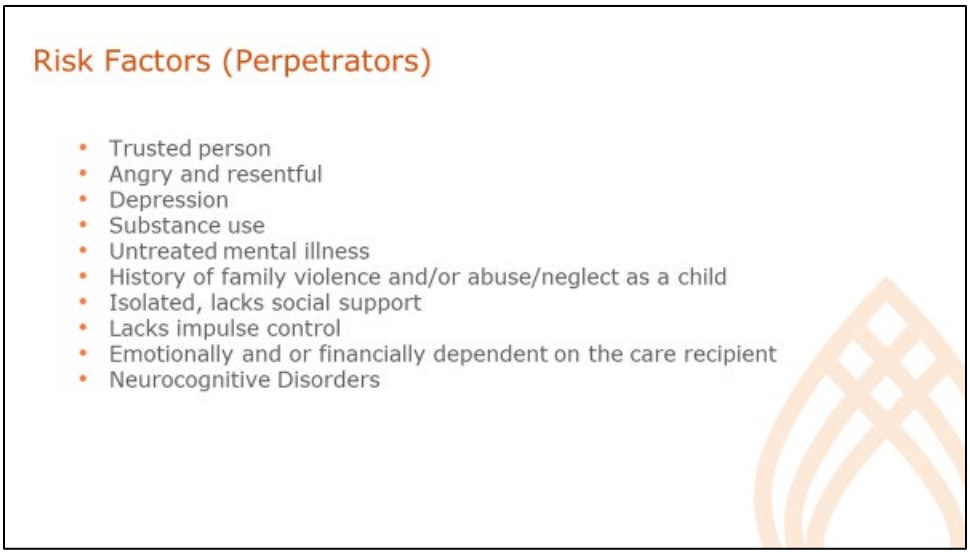
IADLs	***Independent***	***Needs Assistance***	***Cannot Perform***
Grooming	○	○	○
Oral Care	○	○	○
Climbing stairs	○	○	○
Shopping / Errands	○	○	○
Cooking	○	○	○
Managing Meds	○	○	○
Using a phone	○	○	○
Housework	○	○	○
Driving	○	○	○
Laundry	○	○	○
Managing finances	○	○	○

Caregiver: _____

ADLs	***Independent***	***Needs Assistance***	***Cannot Perform***
Bathing	○	○	○
Dressing	○	○	○
Eating	○	○	○
Transferring	○	○	○
Assistive Walking	○	○	○

IADLs	***Independent***	***Needs Assistance***	***Cannot Perform***
Grooming	○	○	○
Oral Care	○	○	○
Climbing stairs	○	○	○
Shopping / Errands	○	○	○
Cooking	○	○	○
Managing Meds	○	○	○
Using a phone	○	○	○
Housework	○	○	○
Driving	○	○	○
Laundry	○	○	○
Managing finances	○	○	○

Slide #38: Risk Factors (Perpetrators)



Explain that as we saw earlier when we discussed theories and dynamics, people who become caregivers who are neglectful or abusive, do so for a variety of reasons. The slide covers some common risk factors which enable someone more likely to commit abuse. It must be understood that none of these are justifications or excuses for abuse and should never impact an APS professional's findings. They are simply to help understand some underlying dynamics behind the neglect, which may impact the service plan and interventions.

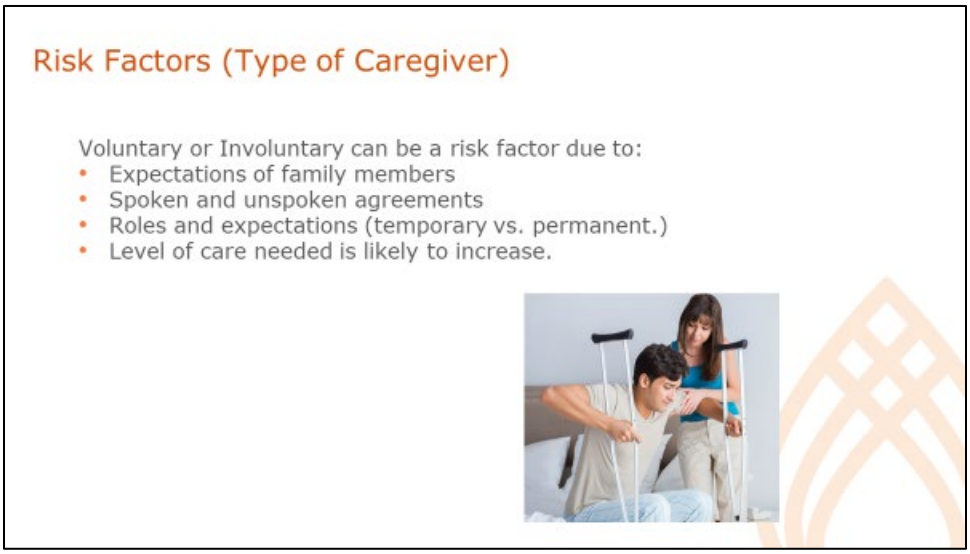
As mentioned with client risk factors, these risk factors on the slide do not guarantee that someone failed or will fail to carry out their responsibilities as a caregiver.

Review slide.

- Trusted person
- Angry and resentful
- Depression
- Substance use
- Untreated mental illness
- History of family violence and/or abuse/neglect as a child
- Isolated, lacks social support
- Lacks impulse control
- Emotionally and or financially dependent on the care recipient
- Neurocognitive Disorders

- If a caregiver has a medical condition involving changes to the brain, they may behave inconsistently or become increasingly physically aggressive and is unable to control their behavior.

Slide #39: Risk Factors (Type of Caregiver)

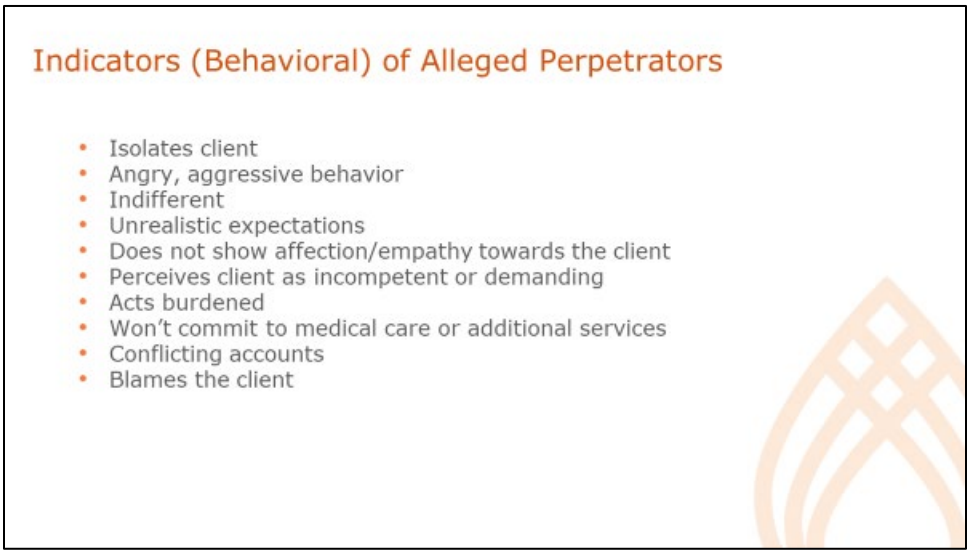


Share that earlier we mentioned some dynamics that may be occurring when someone is failing or neglecting to provide care. Some of the dynamics had to do with lack of education, situational, and cultural considerations. These can become more apparent when there is an unpaid or informal caregiver.

Whether the caregiver or voluntary or involuntary can also be a risk factor due to the following:

- **Expectations of family members** regarding who should assume caregiver role. For instance, sometimes people are pressured into becoming caregivers, either by other family members, or their own guilt.
- **Spoken and unspoken agreements** regarding expectations of caregiver and patient. For example, in some families and cultures, the unmarried daughter was often expected to care for her aging parents until they died.
- **Roles and expectations (temporary vs. permanent.)** For instance, A daughter was in between jobs and agreed to come stay with Dad after his surgery for 3 weeks on a temporary basis. However, Dad's level of care increased and required a permanent caregiver and the daughter couldn't find another caregiver to replace her.
- **Level of care needed is likely to increase.** In some situations, a person assumes the care, but does not clarify what the patient needs and/or expects. The years go by; the burden of care becomes greater and the caregiver cannot or does not want to provide continued care.

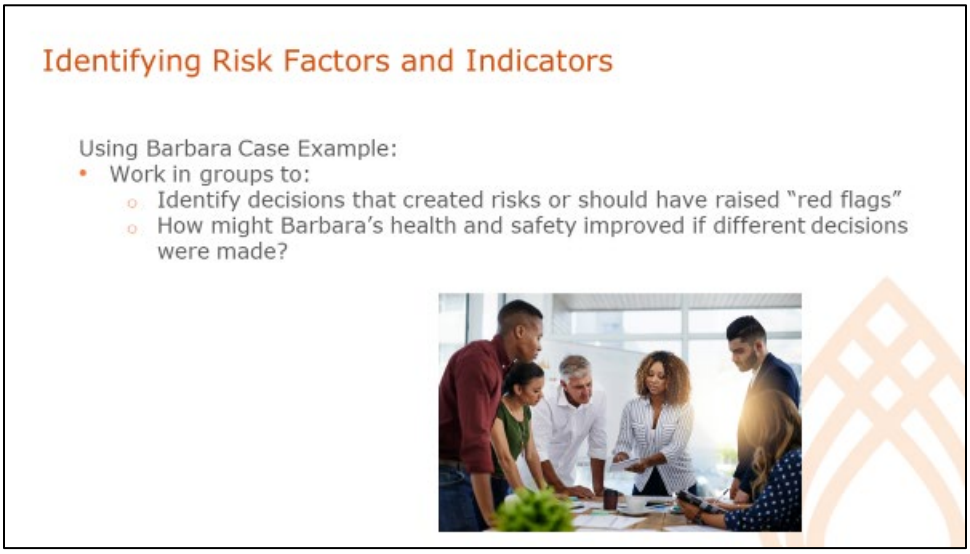
Slide #40: Indicators (Behavioral) of Alleged Perpetrators



Remind participants that indicators are observable signs that risk may be present. **Review** the following Behavioral Indicators of alleged perpetrators of caregiver neglect.

- **Isolates client.** Neglectful caregivers operate most effectively when the client is out of sight and contact with others. For this reason, the alleged perpetrator frequently discourages visitors, phones calls and other communication.
- **Angry, aggressive behavior** towards client. They may alternate between bouts of anger and completely ignoring the client's needs.
- **Indifferent** to client's needs
- **Unrealistic expectations** about what the client can do or what their needs are. These caregivers sometimes have unrealistic expectations of what the client can do to meet their own needs
- **Does not show affection/empathy towards the client.** Why? Parent may have been abusive to the child
- **Perceives client as incompetent or demanding** referring to the client as senile, stubborn
- **Acts burdened** by caregiving responsibilities
- **Won't commit to medical care or additional services**
- Provides **conflicting accounts** of how the neglect occurred
- **Blames the client.** Frequently blames the client for being difficult to care for

Slide #41: Identifying Risk Factors and Indicators



<u>Activity #6: Barbara Case Example (15 minutes)</u>
Small Groups

INSTRUCTIONS

Refer participants to **Handout #5 – Barbara Case Example** in their participant manual.

The following is an example of a situation that went terribly wrong. At a number of critical junctures, decisions were made that had a tragic outcome for the client.

Reads the case out loud:

Barbara, who was living with Alzheimer's, had been in a nursing home as a private pay patient for four years when her children, Ray and Bethany decided to bring her home in November because they felt that it was costing too much. Initially, Bethany cared for her mother, but because she herself has multiple sclerosis, she asked Ray to take over as the care provider.

Ray brought Barbara home to live with him in a remote area far from any resources. When he first brought her to his home in December, he took her to the nearest clinic, where it was noted that she was clean, well-nourished and ambulatory, but very confused. In February, the clinic called Ray several times to schedule a follow up appointment for his mother, but the calls were not returned.

In March, Ray filed a Medicare application on behalf of his mother. In April, he was sent a notice saying that his mother's application was denied because he filed incorrect paperwork. He did not follow-up with a corrected application.

In May, Ray called emergency services for an ambulance. When the EMT's arrived and attempted to lift Barbara from the urine-soaked foam mattress, they discovered that she was stuck to it, so they put her in the ambulance on the mattress. She was taken to the emergency room, where nurses found that she had 32 pressure sores; some bone deep, with severe contractures on her leg muscles, dehydration, and feces caked all over her body, in her hair, and under her finger and toenails.

Hospital staff called Adult Protective Services. An APS professional came to the hospital to interview Ray who claimed that his mother had been clean when she left his house to ride in the ambulance. He said that he had been feeding her Ensure three times a day and changing her diaper "two or three times a day." When asked what he did for a living, Ray said that caring for his mother was his full-time job.

Barbara died three days after her admission to the hospital. The cause of death was listed as pneumonia. No autopsy was performed, and APS closed the case. Law enforcement was not involved.

Small Group Activity: After reading the case have participants form small groups, identify a recorder and discuss the following questions:

1. Identify the decisions that created risks that should raise 'red flags' with regard to Barbara's care.
2. How might Barbara's health and safety have been improved if different decisions had been made at each of these critical points in her story?

Large Group Processing: Ask the groups to report back on the two questions.

1. What are some of the critical junctures: risk factors or indicators (red flags) in this case?
   Possible responses:
   a. *In December, they moved to a remote area away from resources/support services*
   b. *In February when Ray failed to take Barbara to the clinic*
   c. *The clinic failed to follow up with Adult Protective Services when their attempts to reach Barbara and Ray failed*

d. Ray failed to follow up on the denied Medicare benefits application
e. An autopsy was not performed (lack of evidence for caregiver neglect or Serious Bodily Injury charges)
f. Law enforcement was not involved

2. How might Barbara's health and safety have been improved if different decisions had been made at each of these critical points in her story?
   Possible responses:
   a. If Barbara remained near resources/support services her caregiver, Ray, and herself may have been able to receive much needed support as her health began to decline.
   b. If Barbara were taken to the clinic in February for her check-up, she would have had someone else looking in on her health status/care.
   c. If the clinic called APS after their failed attempts to contact Ray and Barbara, an intervention could have been put in place.
   d. Barbara and Ray may have also been able to be linked to home health care to assist with Barbara's case.
   e. If an autopsy was performed, it may have indicated that caregiver neglect occurred. If law enforcement was involved charges of caregiver neglect may have occurred.

Handout #5- Barbara Case Example

Barbara, who was living with Alzheimer's, had been in a nursing home as a private pay patient for four years when her children, Ray and Bethany decided to bring her home in November because they felt that it was costing too much. Initially, Bethany cared for her mother, but because she herself has multiple sclerosis, she asked Ray to take over as the care provider.

Ray brought Barbara home to live with him in a remote area far from any resources. When he first brought her to his home in December, he took her to the nearest clinic, where it was noted that she was clean, well-nourished and ambulatory, but very confused. In February, the clinic called Ray several times to schedule a follow up appointment for his mother, but the calls were not returned.

In March, Ray filed a Medicare application on behalf of his mother. In April, he was sent a notice saying that his mother's application was denied because he filed incorrect paperwork. He did not follow-up with a corrected application.

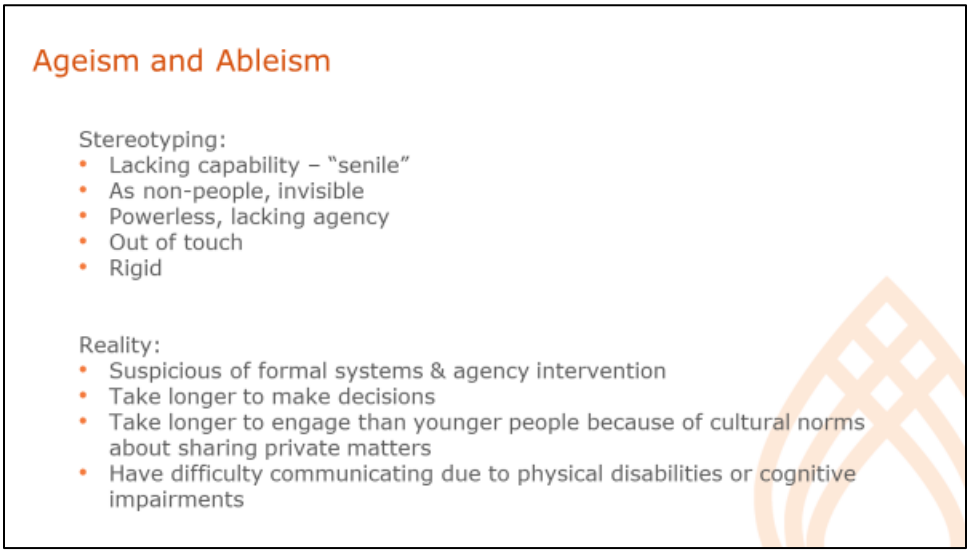
In May, Ray called emergency services for an ambulance. When the EMT's arrived and attempted to lift Barbara from the urine-soaked foam mattress, they discovered that she was stuck to it, so they put her in the ambulance on the mattress. She was taken to the emergency room, where nurses found that she had 32 pressure sores; some bone deep, with severe contractures on her leg muscles, dehydration, and feces caked all over her body, in her hair, and under her finger and toenails.

Hospital staff called Adult Protective Services. An APS professional came to the hospital to interview Ray who claimed that his mother had been clean when she left his house to ride in the ambulance. He said that he had been feeding her Ensure three times a day and changing her diaper "two or three times a day." When asked what he did for a living, Ray said that caring for his mother was his full-time job.

Barbara died three days after her admission to the hospital. The cause of death was listed as pneumonia. No autopsy was performed, and APS closed the case. Law enforcement was not involved.

1. Identify the decisions that created risks that should raise 'red flags' with regard to Barbara's care.
2. How might Barbara's health and safety have been improved if different decisions had been made at each of these critical points in her story?

Slide #42: Ageism & Ableism



Share that holding views of the following stereotypes with regards to aging may be either risk factors or risk indicators of perpetrating caregiver neglect

Stereotypes that older adults are:

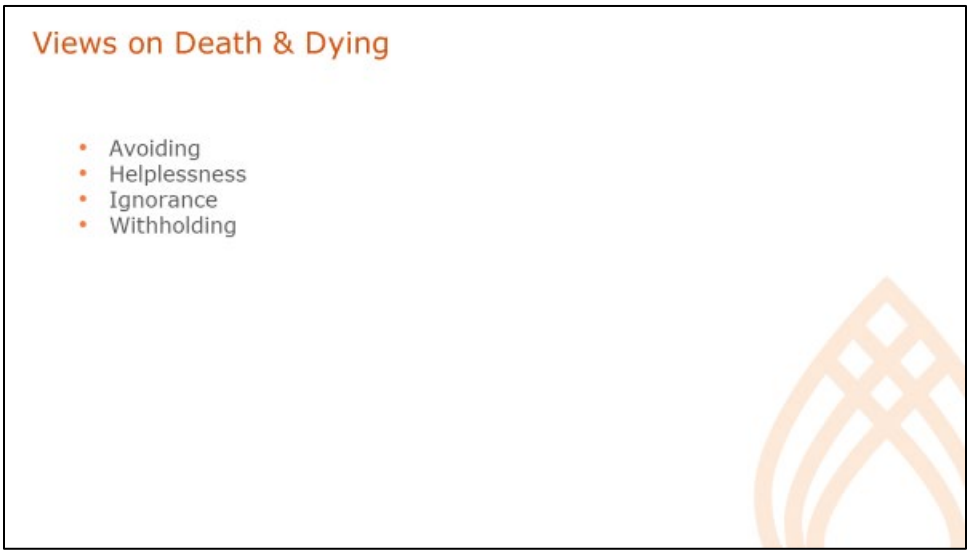
- Lacking capability – "senile"
- As non-people, invisible
- Powerless, lacking agency
- Out of touch
- Rigid

These stereotypes could lead to increased perpetration. When, in fact some older people may be:

- Suspicious of formal systems & agency intervention
- Take longer to make decisions
- Take longer to engage than younger people because of cultural norms about sharing private matters
- Have difficulty communicating due to physical disabilities or cognitive impairments

These stereotypes also align with adults with disabilities abuse/neglect.

Slide #43: Views on Death & Dying



Another potential contributor to caregiver neglect that we should take under consideration is the issue of death and dying. This can be a contributor if the caregiver holds certain attitude about death and dying.

Ask about following concepts.

What do you think "avoiding" means?

- *Possible answers: Avoid contact with person due to fear that they will die on the caregiver's watch (unintentional neglect because they do not provide the needed care giving services) OR avoiding because they do not want to watch them die, see them in that physical or mental state.*

How about helplessness?

- *Answer: The caregiver may feel helpless to prevent the impending death, or to ease the pain of the person they are caring for.*

How may ignorance be a risk factor for caregiver neglect?

- *Answer: The caregiver may not understand the dying process or the scope of care thus fail to identify dying person's need for palliative care, which is beyond their care providing ability. They may be unaware of available hospice services or other sources of comfort such as spiritual, cultural, or social.*

How about withholding?

- *Answer: A caregiver may withhold treatment to speed up the dying process or wish to avoid spending additional resources to provide adequate care.*

While many APS professionals have experienced the death of at least one client, they too often have difficulty dealing with the possibility. In working with someone who is providing care to a terminally ill individual, it is important to confront this reality with sensitivity, and not to collude with denial.

ASSESSING NEGLECT IN FIVE DOMAINS
TIME ALLOTTED: 45 minutes

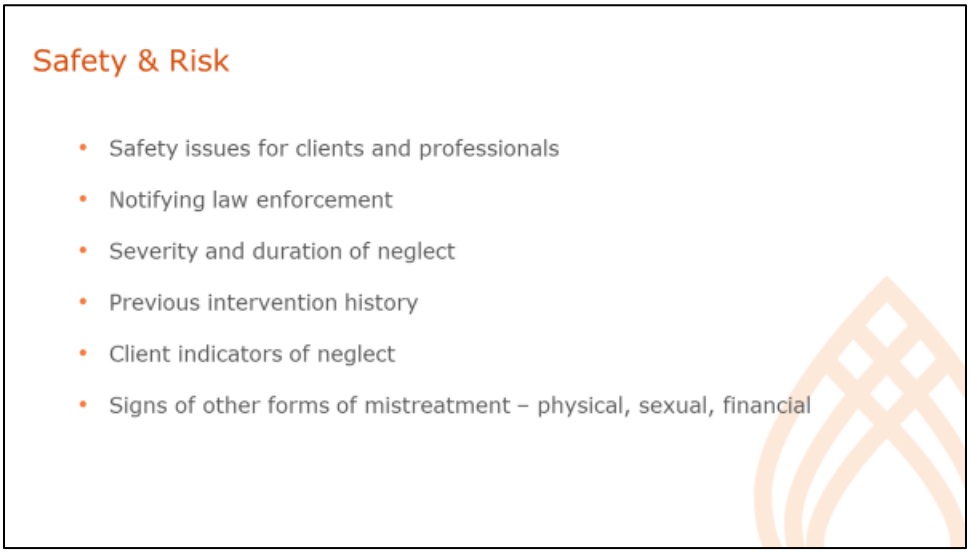
Slide #44: Five Domains of Assessment

In assessing caregiver neglect, it is important to include all aspects of the client's situation including:

- Safety & Risk
- Living Environment
- Physical & Medical Impairment
- Financial and Social Situation
- Decision-Making Ability and Capacity

Let us now take a look at each one individually.

Slide #45: Safety & Risk



Things that APS professionals need to be concerned with in regard to safety and risk domain include:

Safety issues for clients and professionals

- Are there safety issues for clients and professionals?
- Perpetrator's past history of threats, violence, arrest, incarceration, the presence of weapons and/or animals that may attack.
- Possibility of danger to the APS professional or other people in the home.
- Is there a safety plan for the client?

Notifying law enforcement

- Should law enforcement be notified, why and what's their role?
- Evidence that the client has suffered serious bodily harm or that a crime has been or is being committed.

Severity and duration of neglect

- How serious is the neglect and how long has it been going on?
- How extensive is the harm to the client – both physically and emotionally?
- When did it start?
- Is it episodic or continuous? Who has observed/documented it?

Previous intervention history

- Previous intervention efforts on the part of family, friends, healthcare providers, APS and/or law enforcement.

Client indicators of neglect

- Physical evidence, emotional behaviors

Signs of other forms of mistreatment – physical, sexual, financial

- Evidence of bruising, untreated wounds or fractures, genital bruising, unpaid bills, lack of food, utilities

Slide #46: Living Environment

APS professionals' considerations in the living environment domain.

Dirty, chaotic living space

- Is the yard full of clutter or debris, the exterior of the home uncared for?
- Is the home cluttered, dirty, disorganized?
- Is the bedding soiled?
- Are there leaks in the ceiling, holes in the floors, dangerous stair treads, or broken windows?

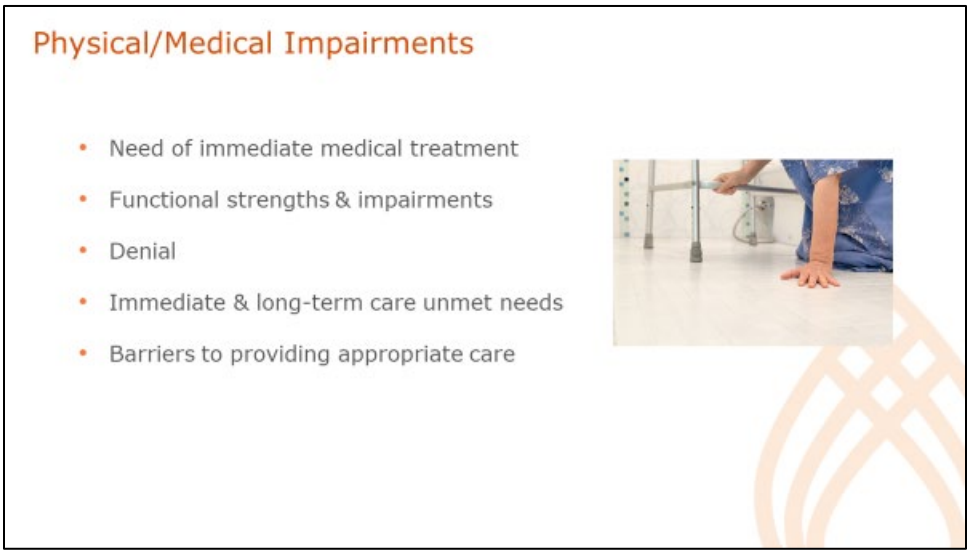
Multiple animals and/or vermin

- Are there multiple animals and indoor evidence of animal waste?
- Is there evidence of rodent chewing and droppings?
- Are there flies and insects in bedding, on food?

In a high-crime area

- Does the client live in a neighborhood in a high crime rate area with limited services and an increase risk of harm?

Slide #47: Physical/Medical Impairments



People experiencing caregiver neglect may be suffering from medical and/or physical conditions such as illness, dehydration or malnutrition, wounds, fractures, immobility or dementia. Here are some factors to consider:

Need of immediate medical treatment

- Does the client need immediate medical treatment?
    - Examples: Sudden loss or impairment of vision in one or both eyes, undiagnosed chest pain, cyanosis (blue coloration) of lips, face, or limb indicating blood insufficiency, sudden extreme undiagnosed confusion.

Functional strengths & impairments

- What is the client's physical and cognitive strengths and limitations?

Denial

- Do they deny that neglect is occurring?
- Are they protective of and/or fear of the alleged perpetrator?
- Do they agree to assistance?

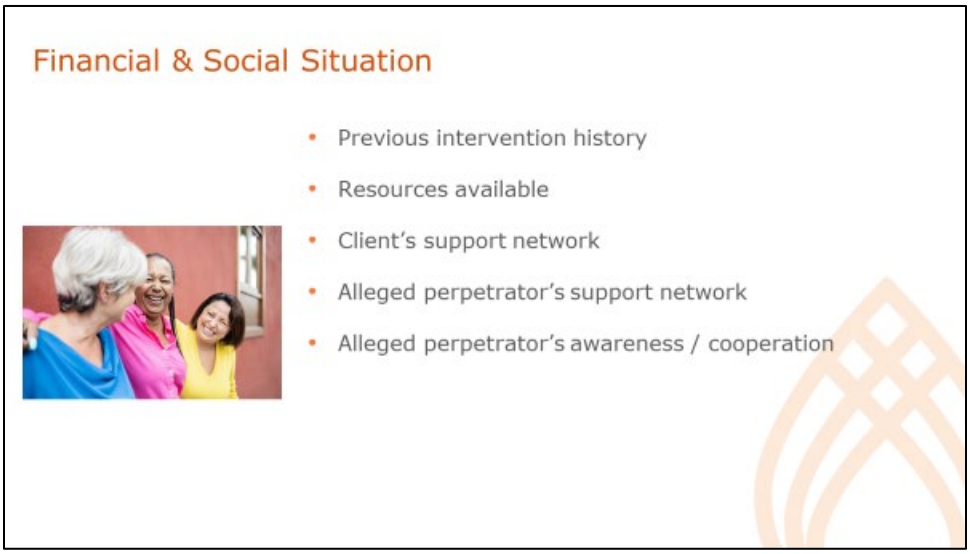
Immediate & long-term care unmet needs

Examples: Wandering, violent behavior, need for medical or personal care beyond the training or ability of a non-professional caregiver

Barriers to providing appropriate care

Examples: A lack of awareness of medical treatments or resources, language barrier preventing the caregiver from seeking help, avoidance of seeking help due to immigration status.

Slide #48: Financial & Social Situation



Review slide then **ask: "**How would you assess for each of these areas? What questions would you ask?

Possible answers are given below.

Previous intervention history

- *Has the neglect been continuous over time or have there been periods when the care was better? When?*
- *Why did the level of care deteriorate?*

Resources available

- *What is the client's current financial situation?*
- *Are there sufficient resources to meet client's immediate needs?*
- *What about long term needs?*

Client's support network

- *Who is the client's support networks?*
- *What are their relationships to the client?*
- *What are they willing to do, or not to do on behalf of the client?*
- *Are their offers of assistance realistic, given the history of the relationship?*
- *What are their assessments of the situation?*

Alleged Perpetrator's support network

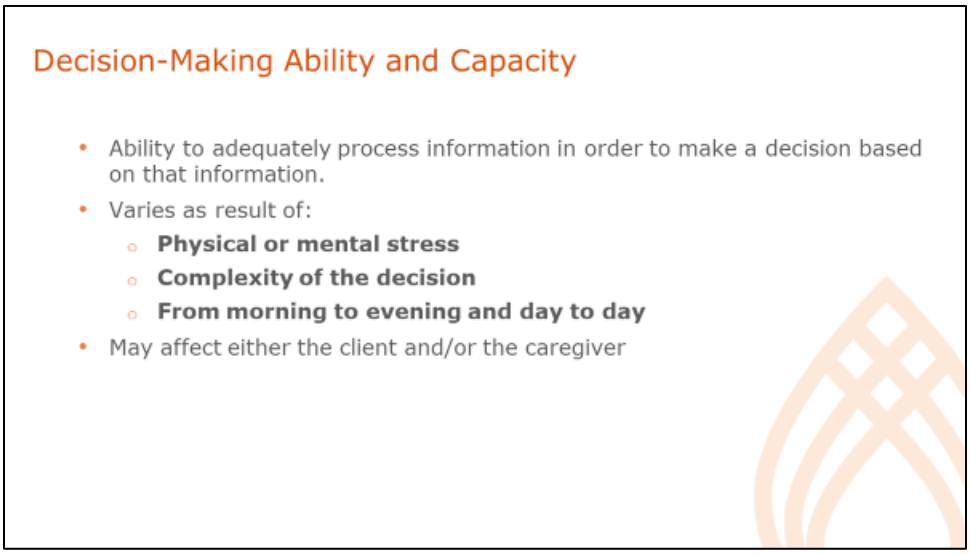
Alleged Perpetrator's awareness

- *What is the perpetrator's physical, mental, and functional status?*
- *Does the perpetrator admit that the care has been inadequate?*
- *Does he/she understand the connection between the failure to provide care and the harm to the victim?*
- *Does he/she attempt to minimize the severity of the neglect and/or the impact on the victim?*
- *Does the perpetrator blame the victim or others for the situation?*
- *Does the perpetrator blame situational events such as alcoholism, loss of a job, or a divorce for the lack of care?*

Perpetrator cooperation

- *Is the perpetrator willing to accept assistance and/or use available resources for the benefit of the client?*
- *What actions (not just words) indicate his/her willingness to accept help?*
- *What interventions have been offered in the past?*
- *Has the perpetrator accepted assistance?*
- *Which interventions in the past have been successful or unsuccessful?*
- *Is the perpetrator doing the best he/she can, given the available resources?*

Slide #49: Decision-Making Ability and Capacity



There are many areas of personal decision-making including medical treatment, sexual/intimate relationships, contractual (such as lease agreements), making a will or participating in research projects.

The ability to make decisions can be affected by the person's physical condition at the time (illness, substance abuse, trauma), or mental state (depression, mania).

Depending on the complexity of the decision, a person may have the ability to make certain informed choices but not others.

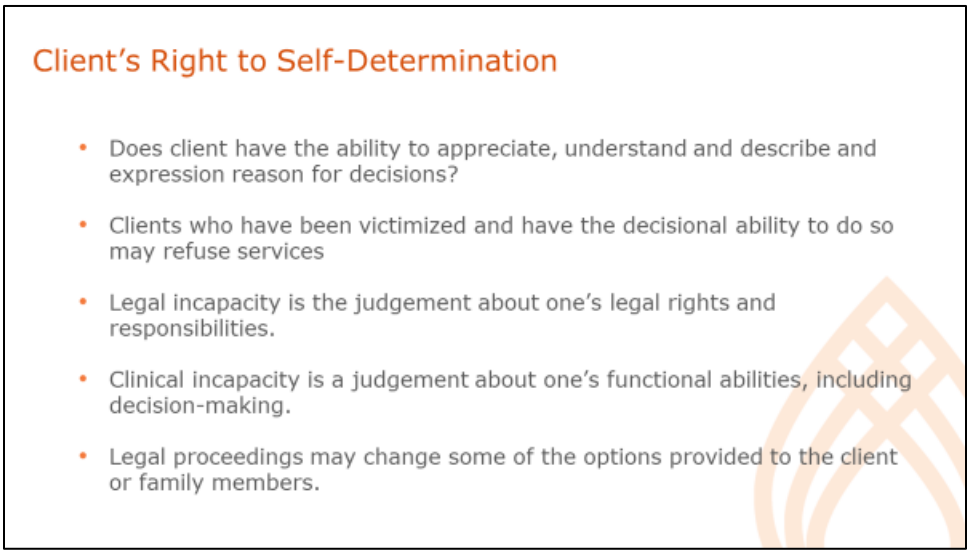
- As an example, someone might be very clear about what they want to eat for breakfast, but unable to agree to a complicated medical procedure. Decision-making ability also may vary from morning to evening, from one day to the next.

APS often screens for decision-making ability when meeting with people. Unfortunately, there is no single test, no gold standard for determining someone's decision-making ability or capacity.

However, through observation, interviewing and assessments, an APS professional can evaluate whether the client understands what is happening to them, what the implications are if help is not provided, and whether to give permission for emergency intervention. The APS professional can ask questions aimed at finding out the following:

- The client understands relevant information – Do you know you have a serious cut on your leg?
- The quality of the client's thinking process – How can you get treatment for your wound?
- The client is able to demonstrate and communicate choice – Do you want to get treatment for your wound?
- The client appreciates the nature of their own situation – What will happen if you don't get your wound treated?

Slide #50: Client's Right to Self-Determination



It is also vital to consider a client's right to self-determination. For instance: does the client have the ability to appreciate, understand and describe, as well as express reasoning for a decision (task specific)?

Clients who have been victimized and have the decisional ability to do so may refuse services as they understand the risks and consequences to themselves. Sometimes clients will make decisions that may be perceived as not the best choice and APS professionals have a responsibility to support their right to do so, while also pointing out the possible negative outcome of these choices.

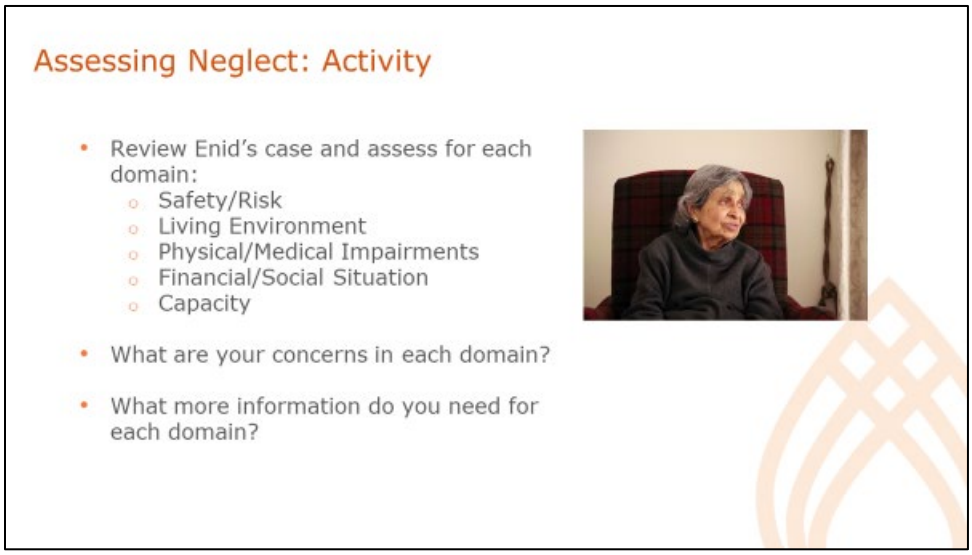
Legal incapacity is the judgement about one's legal rights and responsibilities. Clinical incapacity is a judgement about one's functional abilities, including decision-making. APS professionals, medical staff, caregivers, and even family members are asked to give their opinions and assessments regarding **whether** a client has the mental capacity to handle their financial affairs or to make decisions about their health, where they live, whether they can marry, etc.; however, it is important to bear in mind that the actual legal decision determining mental capacity to handle a person's affairs can only be made by a judge.

Legal proceedings may change some of the options provided to the client or family members. Once legal proceedings are invoked, mediation among family members may be impaired. Whether the legal proceeding is a conservatorship/guardianship hearing, or a criminal case being brought against the alleged perpetrator, the legal process will take precedence over

APS actions. Unless a court or protective order specifying an APS role is received, the primary role of the APS professional is support for the client. At this stage, the client may have a limited power regarding the outcome, which can include incarceration of the caregiver (if this is a criminal proceeding). To support the client, APS staff should be aware that in cases where family members are directly involved, family members sometimes blame the client, if the caregiver is arrested or sentenced to jail or prison. Family members may need to be reminded that the justice system must be impartial in these situations, and that neglectful actions may have legal consequences.

Slide #51: Assessing Neglect: Activity

Note: Prior to the activity, for each domain create a sheet of easel paper with the domain listed (e.g. Safety & Risk) and "Concerns" and "More Info."



Activity #7- Enid Case Example, 25-30 min
Small groups

INSTRUCTIONS

Refer participants to **Handout #6- Enid's Case Example** in their participant manual.

In small groups, **have** participants review the case example and identify where each domain is present. Within each domain, identify:

1. What are the concerns related to this domain?
2. What more information do you need on this domain?

Give small groups 10-15 minutes, then **process** answers as a large group for 10-15 minutes.

Chart answers on easel paper and **supplement** with possible answers listed below.

HANDOUT #6A- Enid Case Example- Trainer Version

Domains and concerns are bolded

Eight years ago, when Marion's husband, Charles, left her and moved out of state, he gave her the deed to their home as part of the divorce agreement. The house was large, and elegant, with four bedrooms and three bathrooms. At the time of the divorce, Marion agreed that Charles' mother, Enid, who was then 83 years old and in good health, could live with Marion until she was ready to make other plans. **He did send Marion a monthly check to cover his mother's expenses but never contacted his mother since moving out.**

Marion lived alone and worked full-time as a realtor. Enid was living in a sunny bedroom on the second floor. Two years ago, after Enid turned 91, Marion moved her to the basement. By then, **Enid had become blind and very frail**. She spent most of her time in bed but was able to make her way to the shower, sink and toilet located in one corner of the basement. **She had no telephone, radio or television, and never had any visitors.**

Enid never left the basement. Enid's furniture consisted of a bed and a table. There was a sliding door leading to an **outside patio but was inaccessible.** The basement had several boxes and unusual furniture stored on one side of the room. **There was a damp and must smell throughout the basement and peeling paint. The cement flooring was uneven. There was evidence of rodent droppings throughout the basement.**

Before going to work, Marion brought Enid a bowl of oatmeal and a glass of juice. She left a glass of water and a sandwich wrapped in plastic on the table for lunch. At night, she brought a bowl of soup and some crackers. She seldom spoke, except to ask Enid if she was "all right." **According to Marion she stated that Enid was no longer able to carry on a coherent conversation, but she felt that Enid appeared to be fine with her living arrangements.** She said that she had promised her ex-husband that she would care for his mother, and she was doing so, even though she felt that Enid belonged in a nursing home.

Enid had not been seen by a doctor for three years and **was not taking any medications.** When asked if she was satisfied with her current living situation, Enid said that Marion was very good to her. **Enid avoided responding directly to questions regarding her meals, living**

arrangement, and her own perspective of the situation. Instead, End proudly displayed a tattered birthday card from Marion, as proof of her daughter-in-law's loving care. Enid appeared uncomfortable with the questions and wanted to end the conversation quickly.

Safety & Risk Domain

What concerns you?

- Fire- can't get out?
- Fall risk- boxes, uneven floor
- Health- rodents
- Isolation- no one in the house/ access issues
- Lack of exercise
- Hygiene
- Ventilation
- Failure to thrive
- Vision

What would you need more information about? Possible answers:

- *How long has the client lived in this situation? (duration)*
- *Have there been previous interventions? (APS cases)*
- *Are there more indicators of neglect/other forms of mistreatment?*

Living Environment

What concerns you? Possible answers:

- *Dark*
- *Moldy*
- *Peeling paint*
- *Temperature*
- *Depressing environment*
- *No entertainment*

What would you need more information about? Possible answers:

- *Running water?*
- *Working plumbing?*
- *Ventilation*
- *Why isn't the door accessible?*
- *Are there windows? Do they open?*
- *Cleanness of Bed & Bath*
- *Is she able to leave the basement area?*
- *Why is she in the basement in the first place? Are there any other available bedrooms that would be more appropriate?*

- *What is the accessibility to food?*

Client's Physical/Medical Impairments

What concerns you? Possible answers:

- *Blindness/Visual impaired*
- *Any assistive devices*
- *Frail*
- *Has not seen a MD for three years*
- *No medication*
- *Malnourished – eating minimal*

What would you need more information about? Possible answers:

- *How much is the client's vision impaired? (to what degree)*
- *Does she have MD?*
- *Is there a system to administer meds? (mediset)*
- *Does she have access to food?*

Financial/Social Situation

What concerns you? Possible answers:

- *Son is reliant on the client's income*
- *Client's ability to access social networks*
- *Lack of resources*

What would you need more information about? Possible answers:

- *Status of income/finances*
- *Power of Attorney*
- *What are her own resources? (pension/savings)*
- *Other family involvement?*
- *Community resources (any other agencies involved? Meals on Wheels)*

Capacity

What concerns you? Possible answers:

- *Does the client understand what it means to have her son reliant on her finances?*
- *Does the client understand how her finances are being administered?*

What would you need more information about? Possible answers:

- *Has the client's capacity been a concern?*
- *Medical notes about capacity issues?*

HANDOUT #6B- Enid Case Example- Participant Version

Eight years ago, when Marion's husband, Charles, left her and moved out of state, he gave her the deed to their home as part of the divorce agreement. The house was large, and elegant, with four bedrooms and three bathrooms. At the time of the divorce, Marion agreed that Charles' mother, Enid, who was then 83 years old and in good health, could live with Marion until she was ready to make other plans. He did send Marion a monthly check to cover his mother's expenses but never contacted his mother since moving out.

Marion lived alone and worked full-time as a realtor. Enid was living in a sunny bedroom on the second floor. Two years ago, after Enid turned 91, Marion moved her to the basement. By then, Enid had become blind and very frail. She spent most of her time in bed but was able to make her way to the shower, sink and toilet located in one corner of the basement. She had no telephone, radio or television, and never had any visitors.

Enid never left the basement. Enid's furniture consisted of a bed and a table. There was a sliding door leading to an outside patio but was inaccessible. The basement had several boxes and unusual furniture stored on one side of the room. There was a damp and musty smell throughout the basement and peeling paint. The cement flooring was uneven. There was evidence of rodent droppings throughout the basement.

Before going to work, Marion brought Enid a bowl of oatmeal and a glass of juice. She left a glass of water and a sandwich wrapped in plastic on the table for lunch. At night, she brought a bowl of soup and some crackers. She seldom spoke, except to ask Enid if she was "all right." According to Marion she stated that Enid was no longer able to carry on a coherent conversation, but she felt that Enid appeared to be fine with her living arrangements. She said that she had promised her ex-husband that she would care for his mother, and she was doing so, even though she felt that Enid belonged in a nursing home.

Enid had not been seen by a doctor for three years and was not taking any medications. When asked if she was satisfied with her current living situation, Enid said that Marion was very good to her. Enid avoided responding directly to questions regarding her meals, living arrangement, and her own perspective of the situation. Instead, Enid proudly displayed a tattered birthday card from Marion, as proof of her daughter-in-law's loving

care. Enid appeared uncomfortable with the questions and wanted to end the conversation quickly.

Safety & Risk

- What concerns you?

- What more information do you need on this domain?

Living Environment

- What concerns you?

- What would you need more information about?

Client's Physical/Medical Impairments

- What concerns you?

- What would you need more information about

Financial/Social Situation

- What concerns you?

- What would you need more information about?

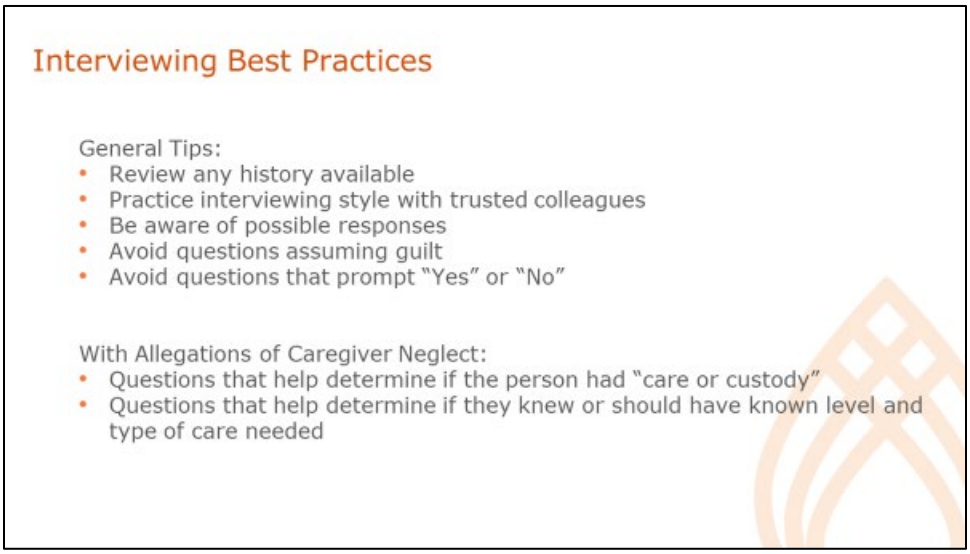
Capacity

- What concerns you?

- What would you need more information about?

INTERVIEWING BEST PRACTICES
Time Allotted: 60-65 minutes

Slide #52: Interviewing Best Practices



These are several items to consider when interviewing all parties involved in an allegation of a case.

- Review any available history on the client and alleged perpetrator. There may be a pattern of unhealthy family dynamics that would be helpful to know prior to the interview.
- Practice your interviewing style – Before seeing the client or alleged perpetrator, try to anticipate some of the information you will need from the client, the alleged perpetrators and collaterals. Rehearse framing your questions with a co-worker or your supervisor.
- Be aware of possible responses to questions – Although you cannot know what answers you will get from a client or caregiver, in pre-planning for the interview it will be helpful to consider what some of the answers you will receive may be. If you are able to anticipate some possible answers, then you can also pre-plan additional questions to be asked based on the anticipated response.
- Avoid questions that assume guilt – Such questions may be inappropriate since you do not know if the person being questioned has committed any wrong-doing. The presumption of guilt will only increase the person's defensiveness.
- Avoid questions that prompt "Yes" & "No" response – Such questions close off the possibility of finding out additional information.
- Focus on interview content, not who made the report – alleged perpetrators often try to shift the inquiry from what occurred to blaming the person who made the report. By doing this, they are trying to place responsibility for the event on someone else.

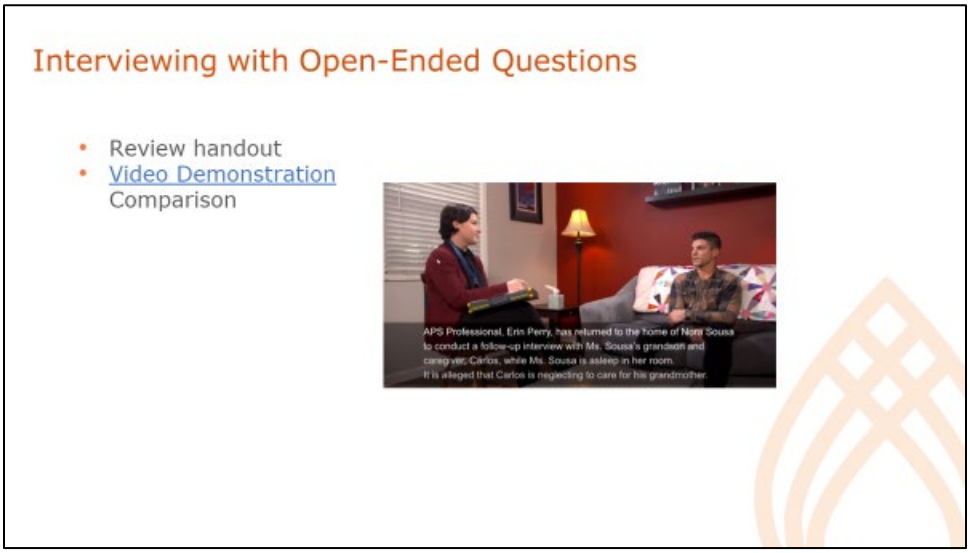
In cases of caregiver neglect, there are some additional interviewing considerations to keep in mind:

- Make sure to ask questions that will help determine if the caregiver was actually responsible for the client.
    - This determination may vary from state to state.
    - In some states, family members and friends who have been caring for the client may be identified as caregivers, whether they consider themselves to be in that role or not, while in some states, 'formal' caregivers may be only paid caregivers.
    - In California, care or custody is language is part of the Penal Code. This is a critical part of a neglect investigation.

Share the differences between care and custody:

- Care of a client means that someone (paid or unpaid had responsibility for meeting their physical, medical, nutritional, and emotional needs.
- Custody means providing that constant supervision when someone cannot provide their own safety.

Slide #53: Interviewing with Open Ended Questions



In the process of conducting investigations, you will often encounter an alleged perpetrator who do not share freely, or even share at all. **Refer** participants to **Handout #7-Interviewing Caregivers Who are Hesitant to Talk: Open Ended Questions**, which provides some questions APS might use when interacting with a caregiver who does not want to provide you with any information.

Trainer Note: Familiarize yourself with the handout and read a few suggestions. Ask participants if they have examples of helpful open-ended sentences that worked for them in interacting with people who are hesitant.

Activity #8 Video Demonstration (10-15 min)
Individual and Large Group

After reviewing the handout, **explain** that you will be showing a clip from a video of an APS professional interviewing the grandson of Nora Sousa, who is her caregiver and is alleged to be neglecting his duties.

Ask that they individually compare some of the APS professionals' questions to the questions on the handout and note anything that was done well in the interview and anything they would change if they were interviewing the grandson, Carlos.

Show Caregiver Neglect Allegation, Home Visit: Alleged Perpetrator Interview from **1:41-5:46**. https://youtu.be/vgXQpNZ--dQ or go to APSWI's Video Tab at https://theacademy.sdsu.edu/programs/apswi/apswi-videos/ and play Caregiver Neglect Allegation, Home Visit: Alleged Perpetrator video.

Invite participants to refer to their handout and point out any questions (or similar) they heard in the video. **Invite** participants to share what went well and what they may have changed.

Handout #7 – Interviewing Caregivers Who are Hesitant to Talk: Open Ended Questions

You may encounter a caregiver who does not share or would rather discuss other topics. Here are some questions you might use when meeting with a caregiver who does not want to provide you with information pertinent to the investigation.

- "What is your day like as a caregiver? Tell me what you do."
- "What does (the client) expect you to do for them?"
- "Tell me what they can do for themselves?"
- "Help me understand what has happened."
- "What happens where there is more to get done than there is time for doing it?"
- "What happens when things are not going so well?"
- "What happens when the client doesn't feel okay about what is going on?"
- "How do you know when the client wants you to do things differently?"
- "What kind of assistance would be helpful when things get overwhelming?"
- "How do you know when things are beginning to get too much?"
- "When do things get to be too much?"
- "What do you do about taking some time to catch your breath?"
- "How do you take care of yourself with everything you have to get done?"
- "What are some of the concerns that have come up in your work here?"
- "How do you make adjustments when things are not going well?"
- "How can the client let you know that they are not doing okay?"
- "What are some of the things you've had to do that you don't want to have to do again?"
- "How do you manage to get everything taken care of?"

- "What are some of the things you are going to try to do differently over the next few months?"

Adapted from the work of Dr. Jerald Shapiro, MSW, MPH, DSW, JD, Professor – San Francisco State University, School of Social Work

Slide #54: When the Alleged Perpetrator Begins to Talk

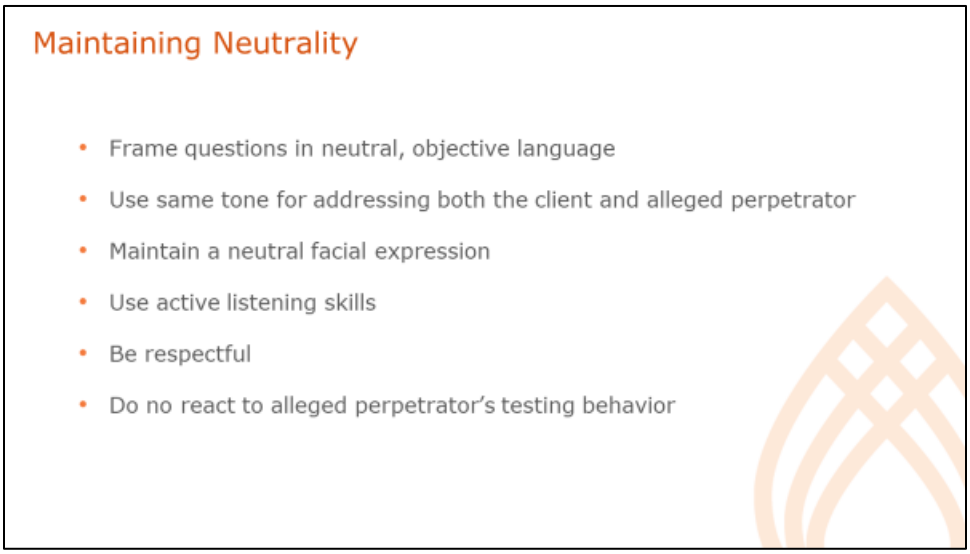
Once an alleged perpetrator begins to talk, here are some suggestions to encourage them to provide additional or follow up information.

Ask participants what they think are meant by each of the points on the slide.

- **Make it easy** - "I'm sorry that this occurred. Can you tell me what happened?"
- **Identify with their needs** – "What are the hardest things for you to do?"
- **Be empathetic** – "You feel as if you can't do it all. What are the tasks you just can't do?"
- **Offer support** - "You may need some help and/or some time off. What would be most helpful for you?"
- **What was their experience? "**You tried to provide good care and feel badly that it is not better. What do you want to do differently?"
- **Precursor or Activating event – "**What caused this to happen?"
- **History –** "What did you learn about care giving from your family?"
- **Bottom line** – "Your mother is not getting the help she needs. What would be some other ways to help her?"

Do not confuse building rapport and respecting the alleged perpetrator with condoning their behavior. In your efforts to gain the alleged perpetrator's trust and gain more information, do not confuse empathy with agreeing that the neglect was justified.

Slide #55: Maintaining Neutrality



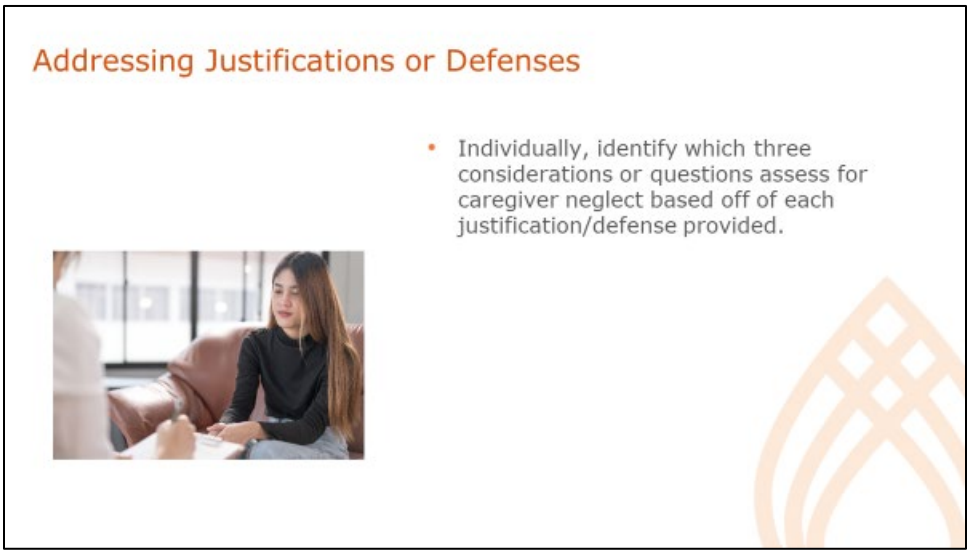
Situations in which a person has been harmed due to neglect can be potentially volatile. Your goal in interviewing the alleged perpetrator is to create an atmosphere of calm and reason.

Review slide:

- Frame questions in neutral, objective language
- Use same tone for addressing client and alleged perpetrator
- Maintain a neutral facial expression
- Use active listening skills
- Be respectful
- Do no react to alleged perpetrator's testing behavior

Share that after training, participants can watch the full Caregiver Neglect Allegation video or find additional tips on interviewing alleged perpetrators on APSWI's website: https://theacademy.sdsu.edu/programs/apswi/apswi-videos/

Slide #56: Addressing Justifications or Defenses



Share that APS can be prepared to either complete additional investigative steps and/or ask follow up questions when an alleged perpetrator provides what they believe is a justification or defense for their actions (or in actions).

Activity #9- Follow Up Questions, 10 minutes
Individual, Large Group

Refer participants to **Handout #8- Justifications and Defenses** in their participant manual. This is a short exercise that explores what additional investigative steps should be taken and/or what questions might need to be asked when assessing someone's justifications and defenses.

Participants should identity which of the "answers" under each justification are appropriate considerations for the justification given.

Have participants work individually on the exercise for about 5 minutes and then process as a large group **asking** for volunteers to share answers.

Handout #8A: Follow Up Questions

(Trainer Version with Answer Key)

For each statement/excuse, identify which three (3) considerations or questions that would assist in assessing an allegation of neglect.

1. **"She is not a good housekeeper. She has always lived liked this."**
    a. Do friends or family members support this statement?
    b. Does the caregiver have a fiduciary responsibility to provide care?
    c. Is there a medical history indicating how often the client was taken to the doctor and what was told to the caregiver about the client's condition?
    d. Is the caregiver providing domestic services?
    e. Are the client's needs for care obvious?
2. **Caregiver states, "I'm doing the best I can. Taking care of him is very difficult."**
    a. Does the caregiver need reassurance that he/she is doing a good job?
    b. Are the client's needs for care obvious?
    c. Does the caregiver have sufficient training to provide care?
    d. Does the client have a history of refusing help?
    e. Should the caregiver be told that he/she should be paid for providing care?
3. **Caregiver states, "I am just doing what she (the client) wants. I am honoring her wishes."**
    a. Are these historical statements of the wishes of the client?
    b. Should the caregiver decide what the client needs?
    c. Does the client have a history of refusing help?
    d. What is the client's capacity to make informed decisions about care, including refusal to accept care?
    e. Does the caregiver have any special training in providing care?
4. **Caregiver states, "He refuses to eat."**
    a. Has the caregiver been instructed on the client's condition, care needs, and how to provide them?
    b. Should the caregiver withhold food until the client gets hungry?
    c. Is there a medical history indicating how often the client was taken to the doctor and what was told to the caregiver about the client's condition?
    d. Does the caregiver have any special training in providing care?

e. Does the caregiver need reassurance that he/she is doing a good job?

5. **Caregiver states, "I didn't know how sick she was, or what she needed."**
    a. Does the caregiver have any special training in providing care?
    b. Does the caregiver appear tired and worn out?
    c. What is the client's health history?
    d. Are these sufficient resources to provide for the client's needs?
    e. Are the client's needs for care obvious?

Answers Key

Question #01 Answer: A, B, D "She is not a good housekeeper. She always lived like this."

- (A) Do friends and family members support this statement (**Assessing for collaborating information to see if there is validity to the statement**)
- (B) Does the caregiver have a fiduciary responsibility to provide care? (**Is there someone who is legally obligated to oversee the well-being of the client?**)
- (D) Is the caregiver providing domestic services? (**Does this activity follow under this caregiver's responsibility or is this service supposed to be provided by someone else?)**

Question #02 Answer: B, C, D "I'm doing the best I can. Taking care of him is very difficult."

- (B) Are the client's needs for care obvious? (**Gathering an understanding of what the expectations are for care**)
- (C) Does the caregiver have sufficient training to provide care? (**Is the remedy for the allegation of caregiver neglect based on the need for additional training?)**
- (D) Does the client have a history of refusing help? (**Assessing between caregiver neglect and self-determination/client's wishes**)

Question #03 Answer: A, C, D "I am just doing what she wants. I am honoring her wishes."

- (A) Are these historical statements of the wishes of the client? (**Assessing if the care provider has an understanding of the current needs of the care recipient.)**

- (C) Does the client have a history of refusing help? (**Assessing if this is based on one particular ADL/IADL activity or various ADL/IADL activities. What is causing the client's resistance? Capacity issue?)**
- (D) What is the client's capacity to make informed decisions about care, including the refusal to accept care? (**Assessing if the client has a clear understanding of the impact to their wishes, capacity issue?)**

Question #04 Answer: B, C, D "He refuses to eat."

- (B) Has the caregiver been instructed on the client's condition, care needs, and how to provide them? (**Assessing if the care provider can understand the scope of care providing needs and is able to perform such functions.)**
- (C) Is there a medical history indicating how often the client was taken to the doctor and what was told to the caregiver about the client's condition? (**Assessing if there is a medical issue that could explain the statement "loss of appetite.")**
- (D) Does the caregiver have any special training in providing care? (**Assessing the care giver's skill level. Does the food need to be prepared in a different way? Does the client need assistance with eating?)**

Question #05 Answer: C, D, E "I didn't know how sick she was, or what she needed."

- (C) What is the client's health history? (**Assessing if the client's needs are beyond the scope of the caregiver's skill set?)**
- Are these sufficient resources to provide for the client's needs? (**Assessing if the client is receiving the appropriate care providing services or is in need of a higher level of care providing.)**
- Are the client's needs for care obvious? (**Assessing if the caregiver should have been able to recognize the client's needs. Intentional neglect?)**

Handout #8B: Follow Up Questions

Participant Copy

For each statement/excuse, identify which three (3) considerations or questions that would assist in assessing an allegation of neglect.

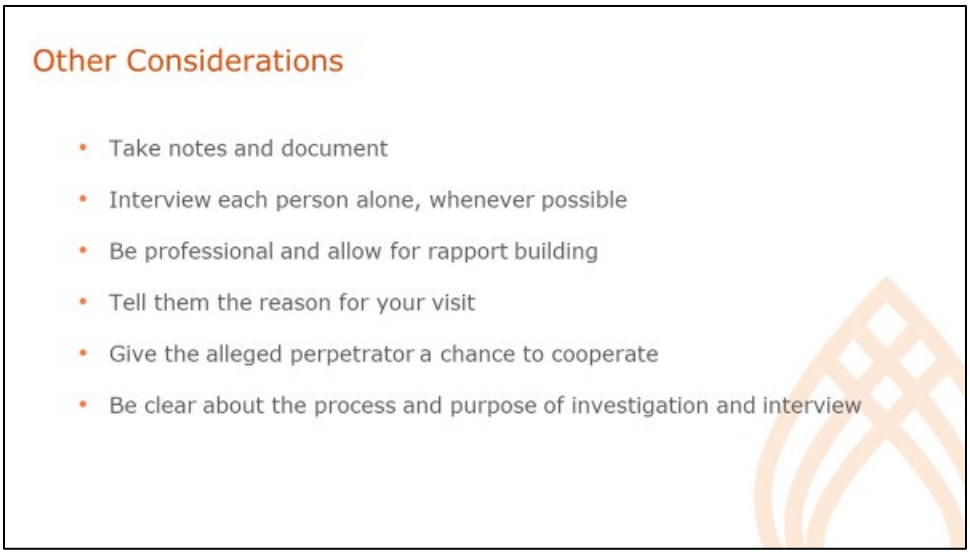
1. **"She is not a good housekeeper. She has always lived liked this."**
    a. Do friends or family members support this statement?
    b. Does the caregiver have a fiduciary responsibility to provide care?
    c. Is there a medical history indicating how often the client was taken to the doctor and what was told to the caregiver about the client's condition?
    d. Is the caregiver providing domestic services?
    e. Are the client's needs for care obvious?
2. **Caregiver states, "I'm doing the best I can. Taking care of him is very difficult."**
    a. Does the caregiver need reassurance that he/she is doing a good job?
    b. Are the client's needs for care obvious?
    c. Does the caregiver have sufficient training to provide care?
    d. Does the client have a history of refusing help?
    e. Should the caregiver be told that he/she should be paid for providing care?
3. **Caregiver states, "I am just doing what she (the client) wants. I am honoring her wishes."**
    a. Are these historical statements of the wishes of the client?
    b. Should the caregiver decide what the client needs?
    c. Does the client have a history of refusing help?
    d. What is the client's capacity to make informed decisions about care, including refusal to accept care?
    e. Does the caregiver have any special training in providing care?
4. **Caregiver states, "He refuses to eat."**
    a. Has the caregiver been instructed on the client's condition, care needs, and how to provide them?
    b. Should the caregiver withhold food until the client gets hungry?
    c. Is there a medical history indicating how often the client was taken to the doctor and what was told to the caregiver about the client's condition?
    d. Does the caregiver have any special training in providing care?

e. Does the caregiver need reassurance that he/she is doing a good job?

5. Caregiver states, "I didn't know how sick she was, or what she needed."

a. Does the caregiver have any special training in providing care?
b. Does the caregiver appear tired and worn out?
c. What is the client's health history?
d. Are these sufficient resources to provide for the client's needs?
e. Are the client's needs for care obvious?

Slide #57: Other Considerations



When conducting the interview with the alleged perpetrator here are some things to be mindful of:

- **Take comprehensive notes for the purposes of clear and concise documentation and in case you must use them for court testimony or other legal purposes.** It is always possible that a case of caregiver neglect will end up in court. Your documentation could be vital in obtaining a conviction, conservatorship, or demonstrating a pattern of behavior. When taking notes, record and date them. Avoid including your opinions, theories, or judgements about what you have observed as these may be inadmissible for legal proceedings and could make it appear that you are biased and acting on your feelings rather than the evidence.
- **Interview them alone** – Moving the interview with the alleged perpetrator out of their physical comfort zone will help you maintain control, as it shifts the power position from the alleged perpetrator to the interviewer. If you are not able to persuade them to come to your office, at least move them as far from the client as possible, preferably outside the home on more neutral ground.
- **Be professional, not friendly, but allow for rapport building and convey respect.** – When you introduce yourself, think of how and when you will provide your name, title, the name of your agency and the purpose of your visit. This sets the tone of the interview, and allows you to start rapport building.

- **Tell them the reason for your visit.** "There's been concern that (name of client) isn't receiving the care they require. I am here to conduct an investigation and get your side of the story." If the investigation gets to this point, it is helpful to know your state statutes.
- **Give the alleged perpetrator a chance to cooperate** but be clear about your role – "I would appreciate your full cooperation to conduct an investigation. My job is to collect all the information necessary to resolve this situation."
- **Be clear about the process and purpose of investigation and interview** – If the alleged perpetrator is uncooperative: refusing to allow access to the client, their medications, possession, etc., or to talk with you inform them that you won't be able to get their side of the story which is important to the investigation. Be firm, not threatening. - When collaborating with law enforcement on a case, you should be familiar with penal or other applicable codes for your jurisdiction. Since not all law enforcement personnel are familiar with elder abuse statutes, it might be advisable to have handouts, approved by your program, to give to responding law enforcement personnel to allow them to get familiar with what their role will be in the situation.

Refer participants to **Handout #9- Interviewing A/P Tip Sheet** and encourage them to review it when back in the field. Note that this is not specific to just Caregiver Neglect, but provides a helpful structure of an A/P interview and some examples that they can tailor to their investigations.

HANDOUT #9- Interviewing Alleged Perpetrator Tip Sheet

TIP SHEET

Interviewing Alleged Perpetrator

APSWI Adult Protective Services Workforce Innovations

This tip sheet suggests a way to structure your interview with an alleged perpetrator (A/P). Examples are provided to spark ideas. However, it is important to take the examples and make them your own based on what is applicable, your interview style, and APS program policies.

Safety must be considered during intake, when first initiating interview and throughout the entire interview.

Pre-Interview	Examples
Is it safe to conduct the interview? • Consider safety for yourself and your client. • If unsafe (environment, infectious diseases, violence), do not enter.	Weapons—location, any in area of interview Animals—assume any can be dangerous
Should you bring someone with you?	
Screen for anyone in home being ill, exposure to communicable diseases.	"Does anyone in the home have or recently had a fever?"
	Who else is present at location?
If at any point you feel unsafe, EXIT, and call Supervisor.	Identify safe exit should you need to leave quickly.

If conducting a phone or virtual interview, additional safety considerations:

- Are you using a personal phone, computer or other device? Is your number blocked on A/P's display or call back list?
- Can you be located by the A/P?
- Consider consulting with your IT department to ensure that your device is protected from malware.
- Is anyone other than the A/P listening?
- How do you know that you are speaking with the A/P?

Introductions	Examples
• Title/Agency	"Thanks for answering, I'm Jason with Adult Services."
• Cultural Considerations—e.g., is eye contact appropriate? Is shaking hands appropriate?	"Could we talk about your (mom, dad, grandma, etc)?"
• Getting in the door.	"I'm a Social Worker with the County."
• Wear or display badge/ID.	"I'm from Aging and Adult Services."
Spend time to build Rapport	
Have a conversation, not an interrogation.	Acknowledge décor, pictures, etc. in environment.
Create an environment for disclosure.	"Thank you for taking time to talk to me."
Demonstrate respect for their time.	"Tell me about yourself…" (job, military, interests)
	"What do you enjoy doing?"
Explanation of Events: one allegation/subject at a time	
Let A/P narrate.	"We received a report about some concerns regarding your Mom's health (safety, finances)."
Open ended questions.	"I was hoping you could tell me more about…."
	"I would really like to hear from you and get your perspective on what has been happening."
Discuss one allegation at a time – ask directly.	"Help me understand how your dad got that bruise?"
Make sure that your questions are answered and not deflected.	"Perhaps my question was not clear," then repeat the question that was not answered.
	"Thank you for that information. Can you tell me…?" and repeat the question that was not answered.

Clarifying Questions

Only after getting the explanation of events, go back to ask clarifying questions. By topic or events. Existence of collaterals or information/evidence supporting the account. Explore justifications and defenses.	"Do I correctly understand that (repeat what you have been told)?" "If I heard you correctly, you said that he called you a name, and you became angry. What is the next thing that you did?" "Do you have a copy of the POA/contract/form you described?" "Have you shared what happened with anyone else?"

Educate if Appropriate

Describe relevant laws or rules/regulations. Remain objective and neutral as you educate-- do not label the person.	"What appears to have occurred/what you have told me may be considered elder abuse/neglect, exploitation." "When you left your dad alone overnight instead of staying with him, that may be considered neglect." "How else could you have responded to this situation?"

Engage in Problem Solving as Appropriate

Resources for A/P

"How could we prevent (bed sores, being delinquent in the rent payment, etc.)?"

"Would you be interested in getting additional support caring for your mother?"

"How would you feel about getting support for yourself around your substance use/gambling/mental health challenges?

"What are you comfortable doing?"

Wrapping Up the Interview

Ask if there is anything else the person wants to tell you. **Thank the person for their time and for being willing to speak with you.** • If you know what happens next, inform them if appropriate and safe to do so. • Keep the door to further interaction open—consider if you may want to invite the person to contact you if additional information comes to mind. • Attempt to end on a conversational note .	"What else would you like to tell me that we didn't cover?" "Is there anything else you want me to know?" "Is there anything I did not know to ask you?" "Thank you for speaking with me today. I really value your perspective in helping me understand the situation better." "Do you have any questions for me?" "If you remember anything else or have questions, please call me." If asked, provide a brief summary of what happens next. "I'm going to go back to my office and mail you the resources we talked about."

Post Interview

Document the interview.	As close in time to interview as possible so memory is clear and fresh.

Academy for Professional Excellence
Inquire. Inspire. Impact.

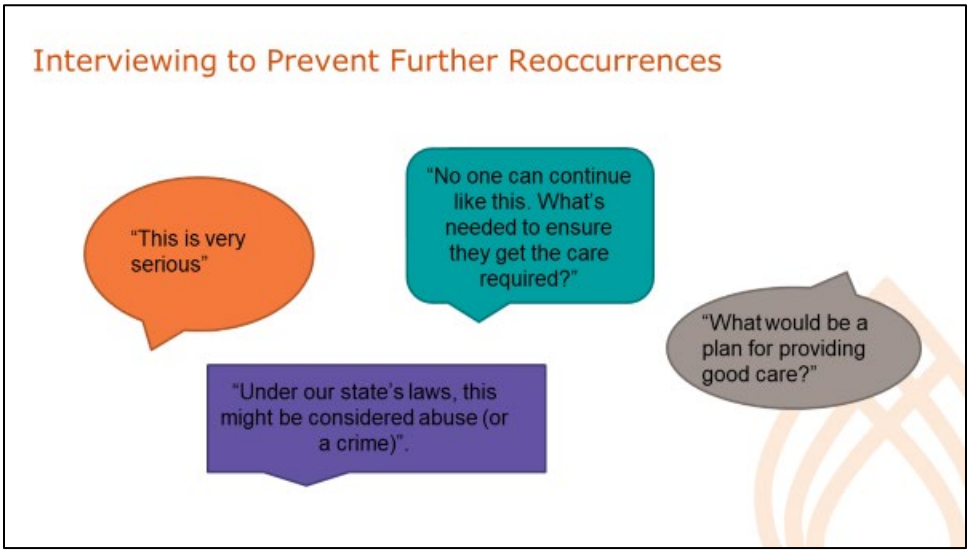
APSWI Adult Protective Services Workforce Innovations

Developed by Candace Heisler, JD in collaboration with Southern CA APS Curriculum Advisory Committee and NAPSA Education Committee- June 2020

For more information about APSWI and/or this tip sheet, contact us at apstraining@sdsu.edu

Or visit our website at: theacademy.sdsu.edu/apswi

Slide #58: Interviewing to Prevent Further Reoccurrences



From the start of the interview, focus on the serious harm to the client, and the fact that there may be legal consequences.

Review the slide and **ask** participants if they have other examples.

- "This is very serious"
- "No one can continue like this. What's needed to ensure they get the care required"
- "Under our state's laws, this might be considered abuse (or a crime)".
- "What would be a plan for providing good care?"

Slide #59: Interviewing Skills

Activity #10 Interviewing Jacob (25 minutes)
Pairs

Trainer Note: Participating in role plays can bring up uncomfortable feelings for some individuals, for a variety of reasons. Participants should not be forced to do role plays. However, individuals are encouraged, if there is discomfort (and they feel safe enough to do so), to develop awareness of their uncomfortable feelings and allow them to simply be there. It is possible that exploration of these feelings could bring about personal insights, growth, and increased resilience, if handled with care, curiosity, and sensitivity. Striving to foster a learning environment that harnesses the power of experiential learning while also respecting an individual's sensitivity to particular topics and/or learning experiences is the goal.

INSTRUCTIONS

Refer participants to **Handout #10– Erika Case Example** in their participant manual.

Have a volunteer read the following scenario aloud:

Erika, age 23, experienced a traumatic brain injury when she fell on her ship as a US Navy Service Member. After being medically discharged, she moved in with her mother as she experienced seizures and has some cognitive impairments. Nine months later, her mother passed away and Erika's older brother Jacob agreed to take care of Erika. When Jacob first agreed to take care of his sister, he was working full-time as a Child Development Professor

at the University. Due to his open schedule, salary, benefits, and two-bedroom home, Jacob and his younger brother, Sam, determined that Erika would be more properly cared for with Jacob. Two years after Erika moved in with Jacob, he was let go due to budget cuts at the University. At the time, Jacob assured Sam that he would be able to find a job at a nearby community college or one of the other universities in the area, and that he would be able to continue caring for their sister, Erika.

After a year of being unemployed and having no luck in his job search, Jacob became increasingly withdrawn from his friends and family. The few times Sam actually saw Jacob he noticed a considerable change in Jacob's appearance. Jacob was disheveled, wearing clothes with stains and holes in them, and Sam could clearly detect alcohol on Jacob's breath. Becoming progressively more concerned about his sister's care, Sam decided to visit Jacob's home and check on Erika. When he knocked on the door, he could hear Jacob yelling inside. When Jacob finally came to the door, he was visibly drunk and enraged at Sam's surprise visit. After a few minutes of Sam trying to calm Jacob down, Jacob slammed the door in Sam's face. Sam walked alongside the house and peered into a window where he saw Jacob throwing objects, but Erika was nowhere to be seen.

Sam called Jacob the next week and demanded to know how Erika was doing. Jacob sounding intoxicated, rambled about how Erika was "just fine," and hung up on Sam. That was the last straw for Sam, and he decided to call APS to have someone check on his sister.

When the APS professional arrived to Jacob's home, they were greeted with the same treatment Sam had experienced. After half an hour, the APS professional was finally let into the home. The sink and kitchen were full of dirty dishes, expired food, and empty bottles of alcohol. The APS professional found Erika in her bedroom. She was malnourished, displayed signs of fearfulness, and her clothes were soiled. The APS professional now needed to interview Jacob.

Exercise: Role-play (15-20 minutes)

Inform participants they will be working in pairs to conduct a role play, interviewing Jacob, while applying the interviewing best practices that have just been covered. **Encourage** them to use any applicable handouts.

Ask them to think about:

1. **How will you approach Jacob?**

2. **What questions will you ask?**
   Example: What is your day like as a caregiver for your sister?

They will both have the opportunity to practice as the APS professional, switching roles after 5 minutes.

Have participants decide who will first act as a Jacob and who will be the APS professional.

Before the role plays begin, **give** participants 2-3 minutes to think of some questions.

Next, **tell** them to begin their role plays.

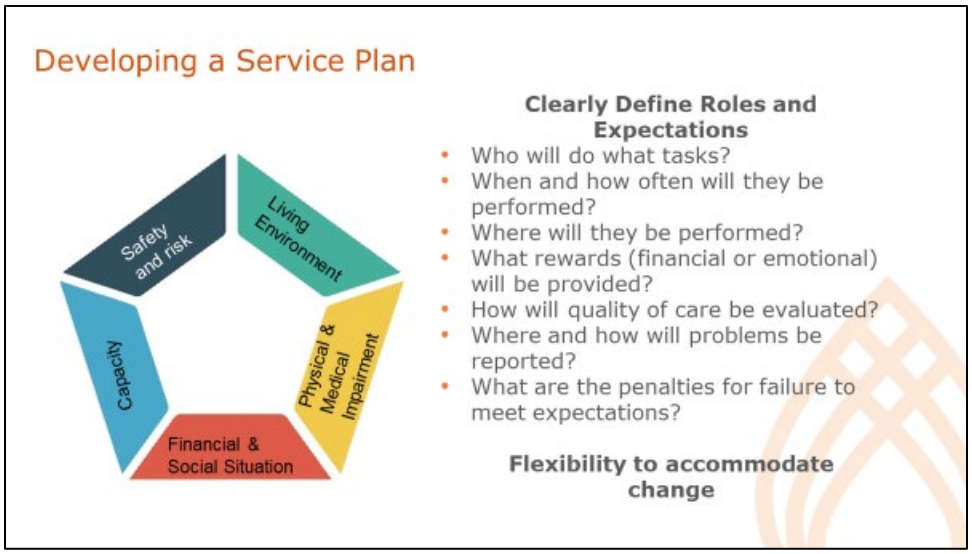
After five minutes, **have** them switch roles:

To close, **process** the role play experience as a large group.

SERVICE PLANNING
Time Allotted: 60 minutes

Slide #60: Developing a Service Plan

Trainer Note: The slide is animated. Wait to click on the clear roles and expectations section until participants have an opportunity to share their ideas.



Earlier today we talked about five domains of assessment. In the next few slides, we'll use those same domains as the framework for developing a service plan. As a reminder, the five domains are:

- Safety & Risk
- Living Environment
- Physical & Medical Impairment
- Financial & Social Situation
- Capacity

Explain that as we go through each domain, participants should keep in mind the need to develop clear and realistic roles, expectations and accountability as they apply to each domain.

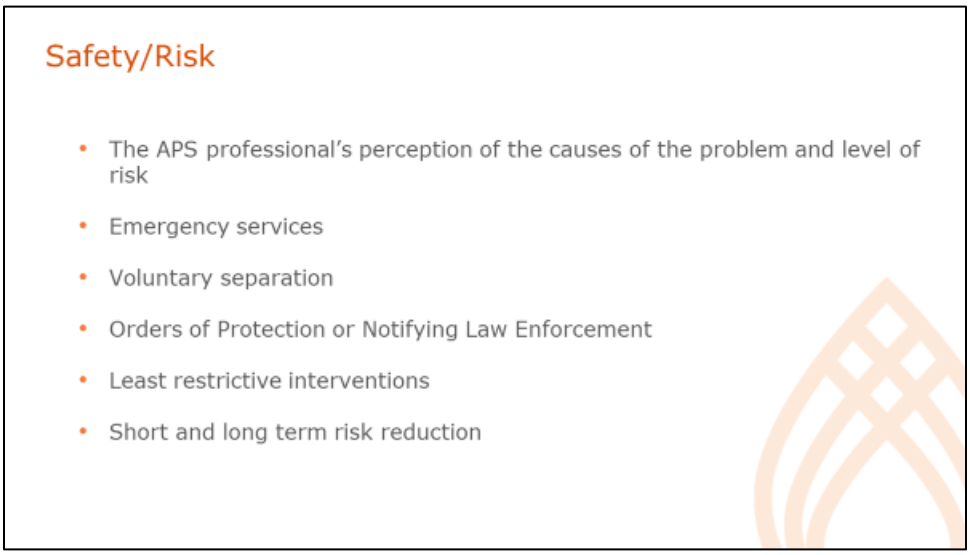
Ask: "What is meant by "clear and realistic roles, expectations and accountability?"

Solicit a few answers and **click** to discuss things to consider with the client and caregiver (when applicable) in order to determine clear and realistic roles, expectations and accountability.

- Who will do what tasks?
- When and how often will they be performed?
- Where will they be provided?
- How the service will be performed?
- What rewards (financial or emotional) will be provided?
- How will the quality of care be evaluated?
- Where and how will problems be reported?

- What are the penalties for failure to meet expectations?
- **Flexibility to accommodate change.** Services should be flexible in order to respond to changes in physical and cognitive abilities.

Slide #61: Safety/Risk



Here are some safety and risk issues to be mindful of when developing a service plan:

- **The APS professional's perception of the causes of the problem and the level or risk** are essential in developing a service plan.
- **Emergency services** provided on site. Is the client in need of an ambulance or emergency medical technician on site?
- **Voluntary Separation-** is the client willing and able to leave the home and go somewhere safe? Should the alleged perpetrator go to a temporary location either voluntarily or with law enforcement's assistance? (Orders of Protection/Restraining Orders)
- Based on the **least restrictive interventions.**
- **Short- and long- term risk reduction.** Long term planning to address safety issues may include replacement of the caregiver, provision of additional in-home services or permanent relocation of the client.

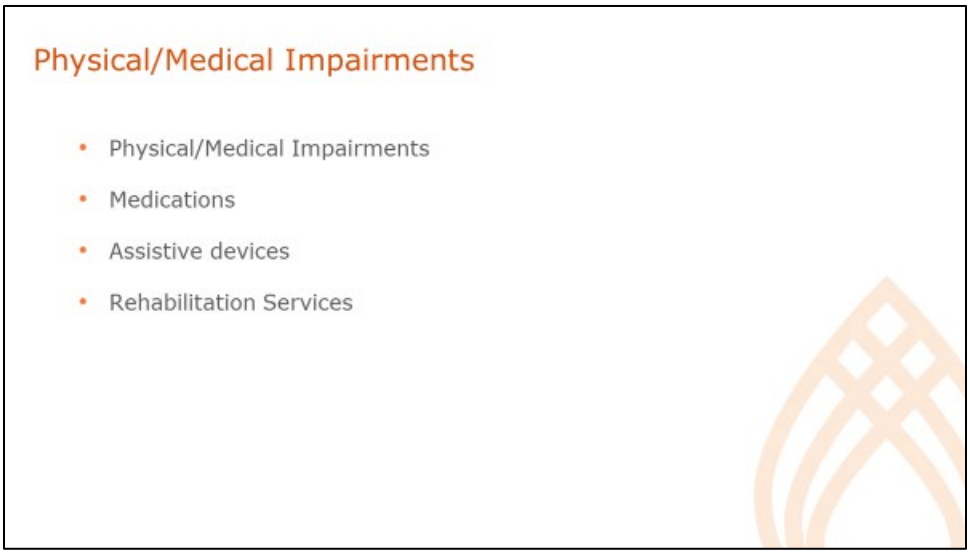
Slide #62: Living Environment

When developing a service plan here are some environmental concerns to keep in mind.

- Immediate environmental changes. For instance, the client's environment might include getting shut-off utilities restored, addressing dangerous temperatures by providing fans or heaters, arranging for emergency plumbing repairs, and providing appropriate clothing for the client.
- Animal care. If animals and their waste are causing a significant health hazard, animal care services and pest removal services may be needed. Removing beloved pets is a delicate matter. Take time to thoroughly explain the problem to the client and involve them in finding acceptable alternatives.
- Cleaning. If heaving cleaning is called for, the client may need to be temporarily removed from the home to avoid exposure to hazardous chemicals.
- Emergency repairs such as fixing leaks in the roof and replacing rotted flooring can be expensive. Some communities and faith groups provide handyman services. Replacing locks and repairing broken windows could be provided through client's service funds.

Ask if participants have had experiences addressing Living Environment situations and how they approached it.

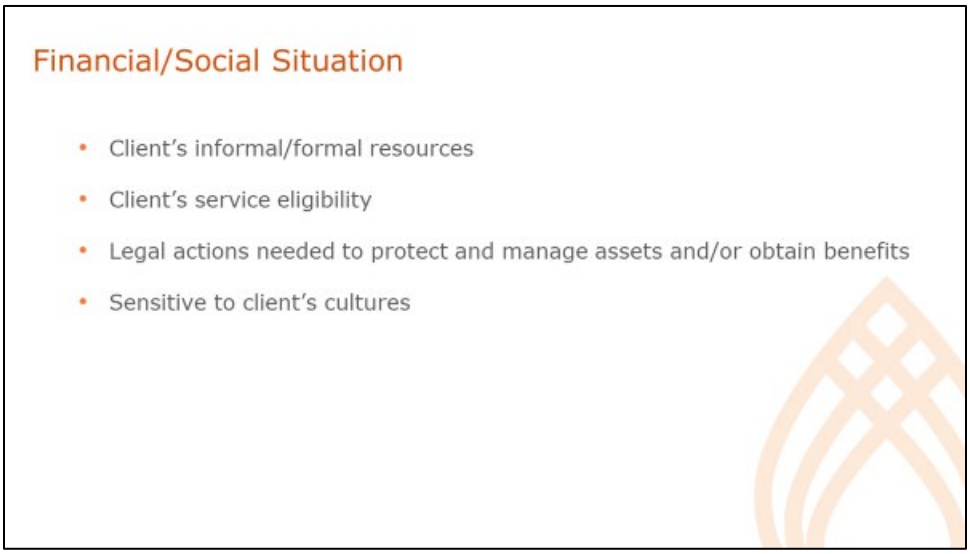
Slide #63: Physical/Medical Impairments



Physical and medical impairments are other factors that should be considered when developing your service plan.

- **Medical treatment.** Arranging for clients to receive comprehensive medical examination is essential in the service planning process. Finding resources for eye and dental care are often time consuming, but also essential in improving the client's nutrition and safety. Some clients will refuse medical evaluation and/or treatment. If this occurs, you will have to try to work with and through their resistance to help ensure their health and safety. For clients with Alzheimer's disease or other types of dementia, medical examinations can provide a baseline for their level of function and documentation for any decline in function.
- **Medications.** An accurate diagnosis will result in medical treatment as well as the administration of appropriate medications.
- **Assistive devices.** Arranging for assistive devices such as wheelchairs and walker can increase the client's mobility and lessen their dependence on the caregiver.
- **Rehabilitation** services are also an important tool in increasing the client's independence.

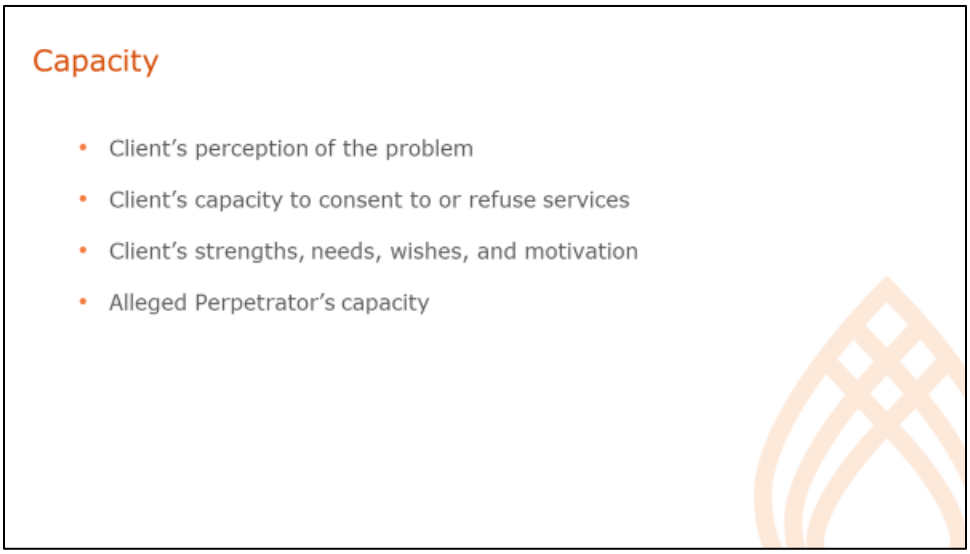
Slide #64: Financial/Social Situation



Understanding the financial and social situation of client is another factor that needs to be taken under consideration when developing your service plan.

- **Client's informal/formal resources.** The client's financial resources and social supports are an essential part of the service planning process. What are their sources and amounts of income? Who are the people in their social network, and how are they willing to assist?
- **Client's service eligibility.** Some clients may not be accessing all of the benefits to which they are entitled, and need assistance in gathering documentation, and completing and submitting applications.
- **Legal actions needed to protect and manage assets and/or obtain benefits.** In some cases, the court appointment of a conservator may be necessary.
- **Sensitive to client's cultures.** Any service plan that is developed should take into account the client's cultures and efforts need to be made to accommodate cultural values. A person's culture may include their spiritual beliefs and practices. Having access to church, mosque, or temple services or activities will be important for their well-being.

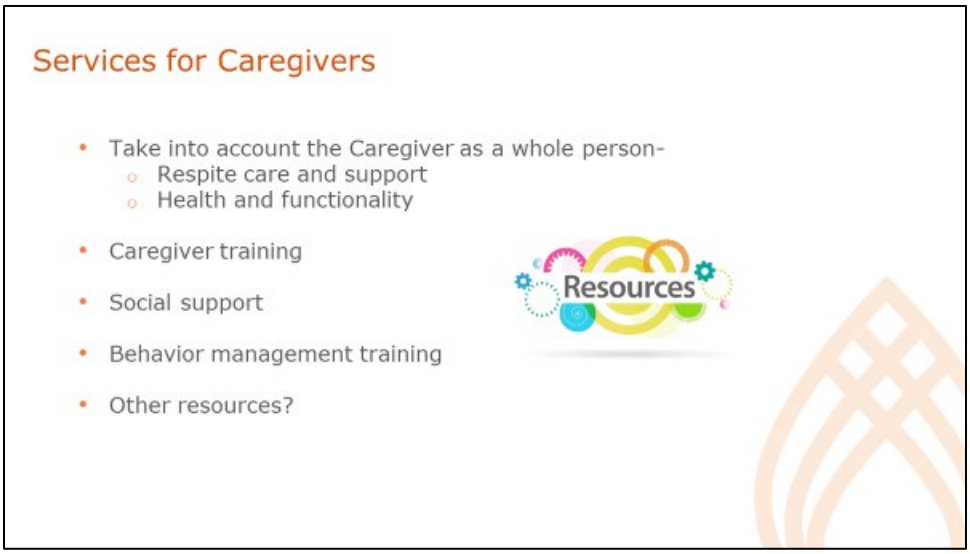
Slide #65: Capacity



Lastly, here are some things to consider when exploring issues of capacity during your service planning.

- **Client's perception of the problem.** In planning services, it is important to start with what the client's understanding is of the problem. A client who appears to have a lack of comprehension about what has occurred may need a full capacity evaluation in order to determine if they have the ability to agree to services.
- **Client's capacity to consent to or refuse services**. In the event that the client lacks decisional capacity, APS can explore if there are pre-determined Power of Attorney's designated or Estate Planning Documents. In some cases, legal proceedings such as the appointment of a temporary guardian may be appropriate.
- **Client's strengths, needs, wishes, and motivation** should guide the type of services that are provided.
- **Alleged Perpetrator's capacity** to understand and respond to client's needs. This is an essential part of the planning process. A cooperative caregiver may accept training, respite care or other supportive services. An uncooperative caregiver, on the other hand, may sabotage services intended to reduce risk and improve the client's quality of life.

Slide #66: What About Services for Caregivers?



When working with caregivers here are some concepts to be mindful of:

- It is impossible to eliminate caregiver burden completely. While interventions for caregivers may be useful sometimes, caregiver (and APS professionals) should not expect that suddenly all of their problems will go away because they are getting help. In addition to which, the health and functionality of the caregiver must be taken into account in planning. Some caregivers have, or will develop physical challenges, or even dementia while acting as a caregiver. If the caregiver role is one that they can no longer fulfill, the APS professional may need to suggest alternate resources.
- Caregiver training and group interventions can be effective in the short term and assist in building emotional support. However, it may not be known if these interventions continue to be effective over extended periods of time.
- Spousal caregivers may benefit from access to more social support, paying more attention to their own health care needs, and low-cost respite care.
- Caregivers of people with dementia do best when they are given behavior management training.

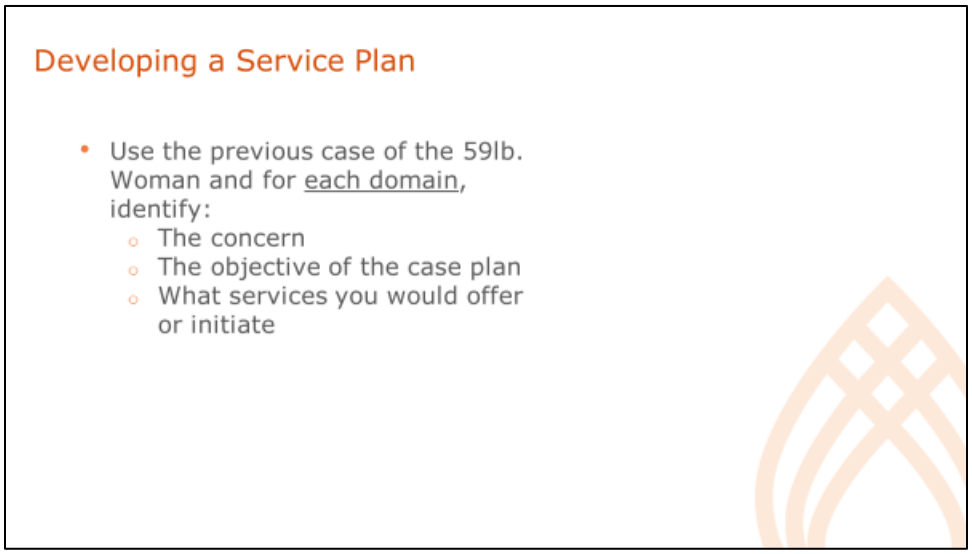
The focus of this training has been on identifying client risk of neglect and providing services to reduce that risk. Sometimes it is important to address the service needs of the caregiver. This is only appropriate in situations in which the caregiver did not wish to neglect or harm the client, is cognizant

of their responsibility to provide appropriate care and is genuinely receptive and cooperative to making changes in the way they provide the care. Keep in mind that some alleged perpetrators may be unrealistic about how things will change. The proof is in whether, in fact, the alleged perpetrator is capable and motivated to do things differently, and able to sustain the changes needed.

Ask: What are some of the resources that you are aware of that may be helpful to caregivers or used to supplement or replace caregiving in situations where caregivers are not providing the assistance that is needed? (Record responses on a flip chart.)

Slide #67: Developing a Service Plan

Trainer Note: Prior to activity, put each domain on its own piece of paper. Chart responses.



Activity #11: The Service Plan, 30-40 minutes
Small Groups

INSTRUCTIONS

Refer participants to **Activity #03 Case of the 59 Pound Victim Part 01** and **Handout #11A-Developing a Service Plan** in their participant manual.

In your small groups, please re-review **Activity #03 Case of the 59 Pound Victim Part 01** which was from earlier in the training. This is your client and the client has returned home.

What are some things you should consider in regard to each of the five domains of assessment?

- Using Handout #11:
  - State the Concern, Objective, Service(s).

Note- It may be helpful to give an example from one of the answers in your answer key.

Give participants about 15 minutes to complete this part of the activity.

Once Handout #11 is completed, **ask** the group to share answers within each domain and what services they would like to put in place. **Chart** responses. See **Handout #11B-Trainer Copy** for some possible answers.

Handout #11A – Developing a Service Plan
Participant Copy

Instructions:

- Re-review the case, below, from Activity #3.
- This is your client and she has returned home.
- What are some things you should consider in regards to each of the five domains of assessment?
- Develop a service plan in your groups.

In 2001, a woman, living with her husband and two adult stepchildren, had a stroke and was paralyzed on her left side. She had two biological children, but after her paralysis, communication with them was soon cut off.

The woman was the primary source of income for her family. As a result of the stroke, she required the use of a wheelchair, and 24-hour care. Many outpatient services were provided after her discharge from the rehabilitation hospital.

In the next four years, Adult Protective Services (APS) received numerous reports concerning the care that the woman was receiving from her family. Each allegation was investigated, and services were offered by APS. Each time services were put in place they were then discontinued by the husband or the victim, who was found to be competent at the time.

In 2005, the woman was taken to a local emergency department by her stepdaughter. She was slumped in her wheelchair, cyanotic, her temperature was 96.7 and she weighed 59 pounds. She had bedsores, one to the bone. She was foul-smelling and had excrement under her nails, in her mouth, on her torso, and on her lower extremities. Her husband had her health care proxy but refused to provide financial information so that she could qualify for benefits.

In the home where the victim had been living, investigators found stained sheets and insects in her bed. The husband was asked what the victim ate on a daily basis; none of the items he named were found in the home. He said that the victim "did not like to eat." He was asked what was being used to treat the bedsores and asked to produce these supplies, but none were located in the home. None of the victim's prescribed medications were current; there were only expired bottles.

Service Plan

Safety/Risk: Actions needed to assure person's immediate safety. Long-term actions needed to reduce the possibility of further risk.

Concern:

Objective:

Services(s) and Goals:

Living Environment: Immediate actions needed to address environmental concerns. Long-term actions needed to improve person's living situation.

Concern:

Objective:

Services(s) and Goals:

Physical/Medical Impairments: Emergency medical care needed to treat person's immediate condition. Long-term treatment needs.

Concern:

Objective:

Services(s) and Goals:

Financial/Social: Resources to provide for person's immediate needs. Legal actions needed to protect and manage assets and/or obtain benefits. Resources needed to build social support.

Concern:

Objective:

Services(s) and Goals:

Decision-Making Ability and Capacity: Level of person's ability to accept services. Level of perpetrator's cooperation.

Concern:

Objective:

Services(s) and Goals:

Handout #11B – Developing a Service Plan (Trainer Answer Key)

Safety/Risk
Concern: Inadequate care for medical and personal needs
Objective: Ensure person's medical & personal needs are met
Services and Goals:

- Follow up with client and put in place a Home Health agency
- Referred to IHSS if appropriate
- Explore personal care provider
- Refer to community case manager for long term follow up

Living Environment
Concern: Unsanitary environment
Objective: Maintain sanitary living environment for health and safety
Services and Goals:

- Refer to IHSS for heavy cleaning
- Enlist family to assist with clean up
- Replace mattress/linen

Physical/Medical Impairments
Concern: Lack of access to medical care/medication compliance
Objective: Decrease barrier to medical services. Set up a system so medication is taken.
Services and Goals:

- Follow up with primary care physician
- Public Health Nurse
- Apply for Paratransit for doctor appointments
- Bathroom accessibility
- Lifeline system
- Obtain current medication list
- Obtain any needed medical devices/assistive devices
- Set up a medication system: mediset

Financial/Social Situation
Concern: Alleged financial abuse by husband & stepchildren
Objective: Protect client's assets
Services and Goals:

- Obtain client's income information
- Explore Rep or Payee services if necessary
- Explore expenditures

- Explore involvement by client's biological children
- Explore alternative DPOA

Decision-Making Ability and Capacity

Concern: Client's decisional ability and capacity unknown (e.g. decision making for health and finances)

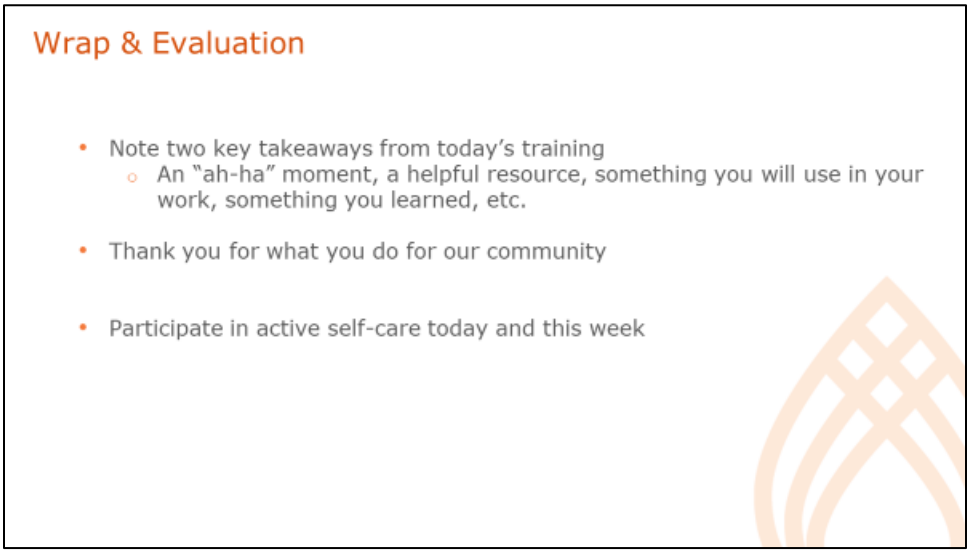
Objective: Determine client's decisional ability and capacity

Services and Goals:

- Refer to neuro, testing, & evaluation
- MH status
- Establish an alternative decision maker besides the husband

CLOSING & EVALUATION
Time Allotted: 15 minutes

Slide #68: Closing & Evaluation



Today we have covered various topics as they pertained to caregiver neglect.

We looked at statutes and definitions and the challenges around these investigations.

We identified various dynamics, theories, risk factors and risk indicators in these cases.

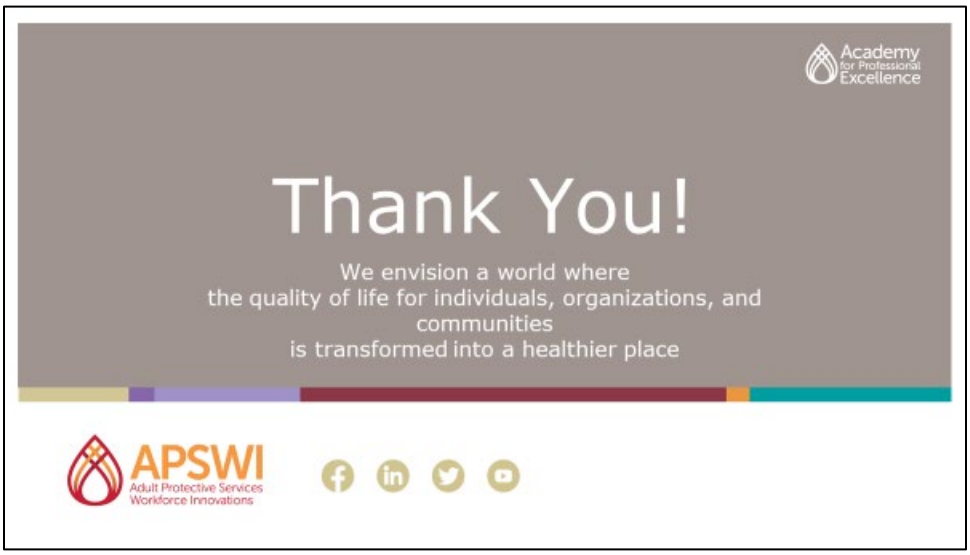
We explored ways to assess for allegations of caregiver neglect and learned the importance of assessing caregiver strengths, weaknesses, and dynamics behind neglect to help inform service planning. Lastly, we covered best practice techniques in interviewing and service planning.

Instruct participants to individually write in their participant manuals two lessons learned or key takeaways from today's training.

Invite people to share theirs.

Ask them to please take the time to complete the evaluations.

Slide #69: Thank You



Thank you for attending today's presentation on Caregiver Neglect!

REFERENCES

Acierno, R. et Al. (unpublished) Final Report: The National Elder Mistreatment Study. National Institute of Justice submitted to the U.S. Department of Justice.

Adult Protective Services (2008). Abuse and Neglect. Family Support Services. Oklahoma Department of Human Services.

Baumhover, L., A., and Beall, S., C. (1996) Abuse, Neglect and Exploitation of Older Persons. Health Professions Press 95-141

Beaulieu, M. and Leclerc, N. (2006) Ethical and Psychosocial Issues Raised by the Practice in Cases of Mistreatment of Older Adults. Journal of Gerontological Social Work Vol. 46, No. 3/4, 61-186.

Bergeron, L. R. (2006) Self-Determination and Elder Abuse: Do We Know Enough?. Co-published simultaneously in Journal of Gerontological Social Work (The Haworth Press, Inc.) Vol. 46, No. 3/4, 2006, pp. 81-102.

Breckman, R. S. and Adleman, R., D. Strategies for Helping Victims of Elder Mistreatment. Sage Human Services Guide #53 Sage Publications, 52-71 and 148-157.

Brown, A.,S. (1989) A Survey of Elder Abuse in One Native American Tribe. JEAN Vol. 1 #2 17-38.

Brownell, P. (1997) The Application of the Culturegram in Cross–Cultural Practice With Elder Abuse Victims. JEAN Vol. 9 #2 19-33.

California Department of Social Services IHSS (2009) Provider Orientation

Centers for Disease Control and Prevention. (2007). National home and hospice care survey. Retrieved from www.cdc.gov/nchs/about/major/nhhcsd/nhhcsdefhospicecare.htm

Cohen, M., et Al (2006) Development of a Screening Tool for Identifying Elderly People at Risk of Abuse by Their Caregivers. Journal of Aging and Health660-685 DOI:

10.1177/0898264306293257.
http://jah.sagepub.com/cgi/content/abstract/18/5/660

Daly, J. M. et Al (2005) APS Workers Job Requirements Associated with Elder Abuse Rates. Social Work in Health Care, Vol. 40(3)89-102.

http://www.haworthpress.com/web/SWHC

Dayton, C., (2007) Caregiver Relationship: Assessing Strengths and Vulnerabilities

Dyer, C. B, et al. (2005) The Key Elements of Elder Neglect: A Survey of Adult Protective Service Workers Journal of Elder Abuse and Neglect, Vol. 17 (4) 1-9.

Fulmer, T, et Al. (2004) Progress in Elder Abuse Screening and Assessment Instruments. American Geriatrics Society 52, 2:297–304.

Guengerich, T., (2020, November 3) Long-Term Care; State Caregiver Profiles 2017-2020, AARP, State Caregiver Profiles 2018-2019 (aarp.org)

Heath, J. M., et Al. (2005) Interventions from Home-Based Geriatric Assessments of Adult Protective Service Clients Suffering Elder Mistreatment. Journal of the American Geriatrics Society, Vol. 53:No.9 1538–1542.

Institute on Aging (2002) A fact Sheet on Caregiver Stress and Elder Abuse. National Center on Elder Abuse.

Kosberg, J., L et Al. (2003) Study of Elder Abuse Within Diverse Cultures. JEAN Vol.15 #3/49 71-89.

Le, Q., K., (1997) Mistreatment of Vietnamese Elderly by Their Families in the US. JEAN Vol. 9 #2 51-62

Legislative Counsel of California. (n.d.). California penal code, Section 368 & 368.5 retrieved from http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=00001-01000&file=368-368.5.

Legislative Counsel of California. (n.d.). Welfare & institutions code § 15610-15610.65 retrieved from http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=15001-16000&file=15610-15610.70.

Lopez, J., Crespo, M. and Zarit, S.H.(2007) Assessment of the Efficacy of a Stress Management Program for Informal Caregivers of Dependent Older Adults. The Gerontological Society of America Vol. 47, No. 2, 205–214.

Lundy, M., and Grossman, S., F. (2004) Elder Abuse: Spouse/Intimate Partner Abuse and Family Violence among Elders. JEAN Vol. 16 #1 85-102.

MacNeil, G. et Al (2009) Caregiver Mental Health and Potentially Harmful Caregiving Behavior: The Central Role of Caregiver Anger The Gerontologist Vol. 50, No. 1, 76–86.

Mellor, M., J., and Brownell, P., Editors (2006) Elder Abuse and Mistreatment: Policy Practice and Research Journal of Gerontological Social Work Vol. 46 #3/4 39, 190, 229-235

Montoya, V. (1997) Understanding and Combating Elder Abuse in Hispanic Communities. JEAN Vol. 9 #2 19975-17

Moon, A. (2000) Perceptions of Elder Abuse Among Various Cultural Groups: Similarities and Differences. Generations Vol. XXIV No. 11, 75-80

Moon, A., and Benton, D. (2000) Tolerance of Elder Abuse and Attitudes Toward Third-Party Intervention Among African American, Korean American, and White Elderly. Copublished simultaneously in Journal of Multicultural Social Work (The Haworth Press, Inc.) Vol. 8, No. 3/4, 2000, pp. 283-303;

Mouton, C.,P. et Al. (2005) Multiethnic Perspectives on Elder Mistreatment. JEAN Vol. 17 #2 21-44.

Nadien, M., B., (1995) Elder Violence (Maltreatment) in Domestic Settings: Some Theory and Research. Journal of Violence and the Prevention of Violence 177-1909

Nagpual, K. (1997) Elder Abuse Among Asian Indians: Traditional Views vs. Modern Perspectives. JEAN Vol. 9 #2 77-92

Nahmiash, D., (2002) Powerlessness and Abuse and Neglect of Older Adults Journal of Elder Abuse and Neglect, Vol. 14 (1), 21-47.

Naik, N., D. et Al (2008) Conceptual Challenges and Practical Approaches to Screening Capacity for Self-Care and Protection in Vulnerable Older Adults Journal of the American Geriatrics Society 56:S266–S270, 2008

National Adult Protective Services Association (2007) APS Core Competencies, Module 8:Dynamics of Elder Abuse

National Association of Adult Protective Services Administrators (2001) Elder Abuse Awareness Kit: A Resource Kit for Protecting Older People and People with Disabilities National Center on Elder Abuse

National Center for Culturally Responsive Educational Systems (2008). *Module 5: Culturally responsive literacy*. Facilitator's manual. Arizona, Arizona State University.

National Center on Elder Abuse (2001) Elder Abuse Awareness Kit, National Center on Elder Abuse.

National Center on Elder Abuse https://ncea.acl.gov/NCEA/media/Publication/NCEA_RB_Ageism.pdf

National Center on Elder Abuse (2004) A Fact Sheet on Caregiver Stress and National Center on Elder Abuse. 9, 28.

National Center on Caregiving/Family Caregiver Alliance. (2014). Factsheet: Caregiving. Retrieved from https://caregiver.org/caregiving on June 4, 2015.

National Council on Crime and Delinquency (2009) Literature Review for Development of a Research-Based Risk Assessment in Adult Protective Services. NCCD

National Public Radio (2021) More Than 9,000 Anti-Asian Incidents Have Been Reported Since the Pandemic Began. Retrieved from https://www.npr.org/2021/08/12/1027236499/anti-asian-hate-crimes-assaults-pandemic-incidents-aapi

Nerenberg, N. (2002) Developing Training Programs on Elder Abuse Prevention for In-Home Helpers: Issues and Guidelines. National Center on Elder Abuse Washington, D.C., Produced by the Institute on Aging(formerly Goldman Institute on Aging)1-16.

Nerenberg, L. (2002) Preventing Elder Abuse by In-Home Helpers. Produced by the Institute on Aging (formerly Goldman Institute on Aging) for the National Center on Elder Abuse, 1-20.

Nerenberg, L. (2002) Preventing Elder Abuse by Family Caregivers:

Caregiver Stress and Elder Abuse. National Center on Elder Abuse, 1-24.

Pablo, S., and Braun, K., L. (1997) Perceptions of Elder Abuse and Neglect and Help-seeking Patterns among Filipino and Korean Elderly Women in Honolulu. JEAN Vol. 9 #2 63-75.

OVC, NCALL, FLETC (2008) Suspect Justifications and Defenses (slide 2.19) Elder Abuse Training for Law Enforcement Participant Materials OVC, NCALL, FLETC

Park, K., et Al (2010) Structuring Decisions in Adult Protective Services. National Council on Crime and Delinquency

Pillemer, K., and Prescott, D. (1989) Psychological Effects of Elder Abuse: a Research Note. JEAN Vol. 1 #1 65-73.

Shapiro, J. (2010) Dealing with Resistance: Open ended Questions and Responses to Behavioral Indicators

Shugarman, L.R. et Al (2003) Identifying Older People at Risk of Abuse During Routine Screening Practices. Journal of the American Geriatrics Society 51 1:24–31.

Sorensen, S., et Al (2002) How Effective are Interventions with Caregivers? An Updated Meta-Analysis. The Gerontologist; Jun 2002; 42, 3; ProQuest Education Journals, 356.

Stanis, P., (2008) Comparing Perpetrator Characteristics in Adult and Child Abuse Situations. Colorado Department of Social Services Adult Protective Services workshop.

Teaster, P., et Al. (2006). The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older. A Report of the National Center on Elder Abuse Prepared by The National Committee for the Prevention of Elder Abuse and The National Adult Protective Services Association

Teaster, P., , et Al. (2006)The 2004 Survey of State Adult Protective Services: Abuse of Vulnerable Adults 18 Years of Age and Older. A Report of the National Center on Elder Abuse Prepared by The National Committee for the Prevention of Elder Abuse and The National Adult Protective Services Association

Texas Department of Aging and Disability Services (no date) The Sandwich Generation Family caregivers: Work/Live the Balance of Child and Elder Caregiving. mmLearn.org

The Associated Press, (November 12, 2021) https://www.npr.org/2021/08/12/1027236499/anti-asian-hate-crimes-assaults-pandemic-incidents-aapi

Thornton, M, and Travis, S.S. (2003) Analysis of the Reliability of the Modified Caregiver Strain Index. Journal of Gerontology: SOCIAL SCIENCES BRIEF REPORT Vol. 58B, No. 2, S127–S132.

Vandeweerd, C. & Paveza, G., (2005) Verbal Mistreatment In Older Adults: A Look at Persons with Alzheimer's Disease and Their Caregivers in the State of Florida. Journal of Elder Abuse and Neglect, Vol. 17(4)11-30.

Vitaliano, P. P., et Al (2003) Is Caregiving Hazardous to One's Physical Health? A Meta-Analysis. The American Psychological Association, Inc., Vol. 129, No. 6, 946–972.

OUR WHY:

REVOLUTIONIZE THE WAY PEOPLE WORK TO ENSURE THE WORLD IS A HEALTHIER PLACE.

Academy for Professional Excellence

theacademy.sdsu.edu

6505 Alvarado Road, Suite 107; San Diego, CA 92120 (619) 594-3546